MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13924 CERTIFICATE OF DEATH after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY b. COUNTY g. STATE Harford Harford MARYLAND Maryland transit permit. Then please remove carbon papers: Pages 1 cremotian, or removal, and in any event, within 72 hours after b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) hours in by Aberdeen Havre de Grace. 4 weeks e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS filled 101 N. Phila. Blvd. Citizens Nursing Home YES NO TO requires that the deoth certificate be executed within NAME OF 4. DATE remove corbon First Middle Manth Day Year the ottending physician and completely sit permit. Then please remove carbon DECEASED 10 19 67 October (Type or print) Emma Albaugh DEATH Knott 5 SEX B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR LIF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** 12, 1881 86 yrs. Manths Days Haurs WIDOWED X September DIVORCED White Female 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 1). BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Homemaker COUNTRY? INDUSTRY Chester, Penna. Home 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Annie M. Crowther James A. Knott 1S. WAS DECEASED EVER IN Ú.S. ARMED FORCES? (Yes, na, ar unknawn) (If yes give war ar dates af service) 17 INFORMANT 16. SOCIAL SECURITY NO. 220-54-7412 Miss M.G. Albaugh (daughter) Aberdeen Md none INTERVAL BETWEEN ONSET AND DEATH 1B. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c). signed by the buriof-tronsit p PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital or attending physician.

• FUNERAL DIRECTOR: After this certificate has been signed by arteriosclenosis DUE TO Canditians, if any, which gave rise ta immediate cause (a), DUE TO stating the underlying cause os the of Health priar to last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Hean)ISEQ8f NO tar 20a. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c. TIME OF INJURY Manth, Day, Year Haur a.m. factory, street, affice bldg., etc.) Nat While at wark at wark 21. I certify that (I) (this hospital) attended the deceased fram_ . 196 (, that (1) (we) last Van 19 63, to 10 OCT 1967, and that death accurred after M, fram causes and an the date stated above saw the deceased alive an V Oct 22b. DATE SIGNED 22a. SIGNATURE ATTENDING DIRECTOR PHYS. director, page should be filed 22d. ADDRESS 22c PHYSICIAN NAME (Type) NAME Baltimore 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION, 23b. DATE THEREOF (County) (State) REMOVAL (Specify) Woodlawn ADDRESS 2Sa. REC'D BY REGISTRAR 2Sb. RFI hurial Oct-13-67 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4 1967 20 M 1/66 Stewart & Mowen Co 108-W-North-Av 21201

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18. CAUSE OF DEATH [Enter		o), and (c).)	WALL SON	11112512	INTERV	AL BI
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saw the deceased alive o	DCT 5 19.	6.7, and that death	occurred a P	M, from the causes	and on the date	state
220. SIGNATURE			TTENDING MED.	STAFF		22
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22c. PHYSICIAN'S NAME (Type)	/ /	1 00 0	d. ADDRESS	4	n 00 1	1
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23a. BURIAL, CREMATION, 23b. D.	ATE THEREOF 23c. NAM	E OF CEMETERY OR CREA		3d. LOCATION (City, 1	own or county)	(
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13931 MEDICAL EXAMINER'S CERTIFICATE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) 1. PLACE OF DEATH o. COUNTY b. COUNTY o. STATE 0 MARYLAND delay (If outside carporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) PM3. write RURAL and give nearest tawn) 59 vrs. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Norrisville Road 8. Give Pages State YES NO R This certificate should be executed within 24 hours ofter death. 3. NAME OF Middle Badders DATE Manth Year Dov John DECEASED CETUD 01-196 (Type or print) DEATH Office along with YFAR 5. SEX 6. COLDR OR RACE R 8. DATE OF BIRTH 9. AGE (In veors IF UNDER IF LINDER 24 HRS NEVER MARRIED lost birthdoy) WIDOWED DIVORCED Mar. 30.1908 lond 2 10o. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF 8USINESS OR 11. 8IRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) Farm U.S.A. Norrisville. Maryland the Chief Medicol Exominer's Laborer 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME pencil Smiley Badders Elizabeth Gibbs File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT AdR 1 Box 253 permit. (Yes, no, or unknown) (If yes give wor or dotes of service)
Yes WW 2 within White Hall, Md. 215-26-5415 Mrs. Mary A. Almony 21161 INTERVAL 8FTWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) buriol-transit ONSET AND DEATH event PART I. DEATH WAS CAUSED 8Y: Declus IMMEDIATE CAUSE (o) DUE TO Ony Conditions, if ony, which gove rise to immediate couse (o). forwarded to = DUE TO stoting the underlying couse Ö. puo OS 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) removol, PERFORMED? the certificate, YES F NO pe 4 shauld be 2Do. EXTERNAL CAUSE WAS 20b. DESCRIBE HDW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.) 3 should PRIMARY Or CONTRIBUTING 0 EXAMINER: CAUSE OF DEATH cremotion, 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, (City or town) (County) (State) 2Dc. TIME OF INJURY Month, Day, Yeor foctory, street, office bldg., etc.) Not While Your FUNERAL DIRECTOR: Page pleose execute of work 21. I certify that I taak charge of the remains described above, held an Autopsy Inspection R Inquiry + and in my opinian for director. deoth resulted from: Natural causes Accident Suicide Hamicide Undetermined manner be retoined CHIEF MEDICAL EXAMINER prior to ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE the funerol DEPUTY MEDICAL EXAMINER **EXAMINER'S** Heolth NAME (Type) Address (Street, city, town, or county) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. 8URIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) 0 Burial (Specify) 10/9/1967 Ayres Chapel White Hall Maryland 25b. REGISTRAR'S SIGNATURE 2So. REC'D 8Y REGISTRAR 24. FUNERAL DIRECTOR VR A15ME (5) DATE OCT 9 1967 Jarrettsville, Md. Charles E. Kurtz 6M 1/67 21084

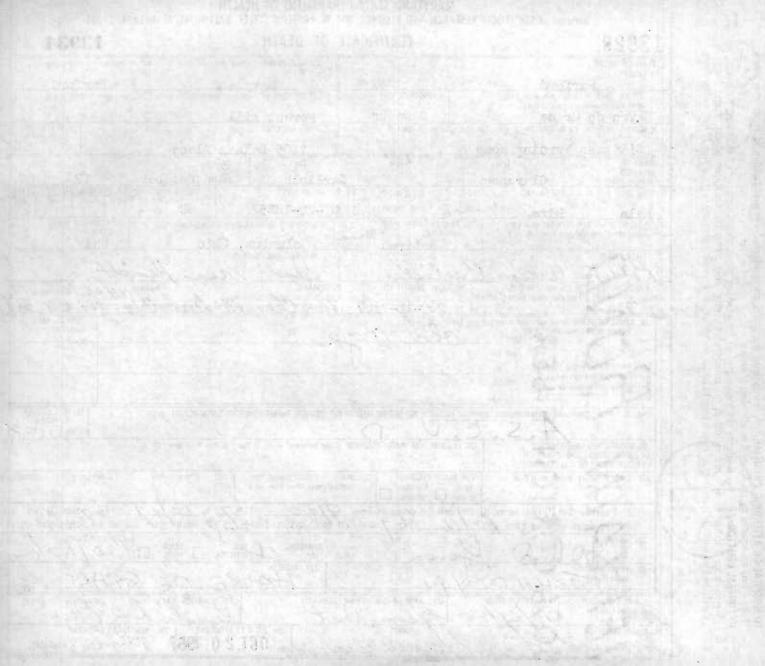
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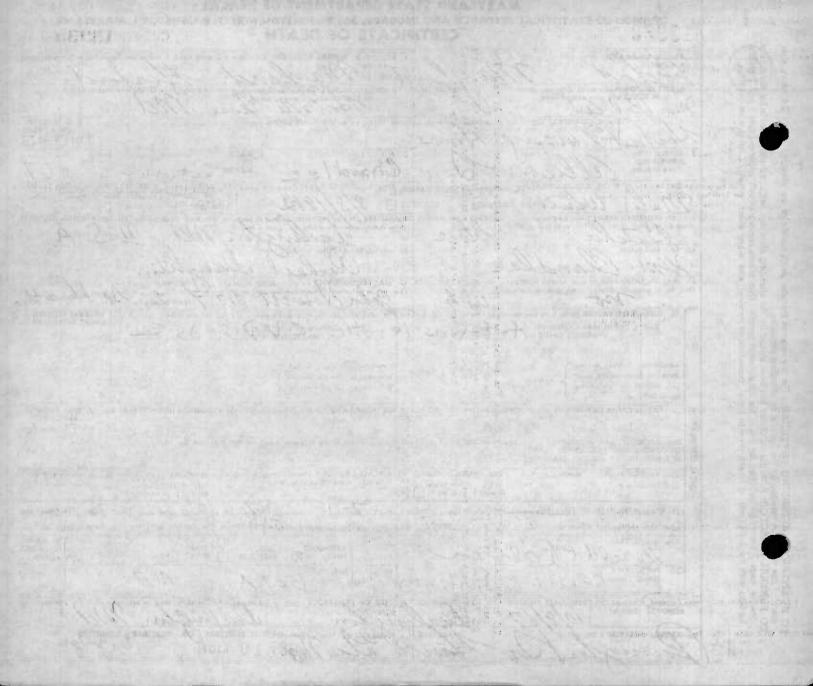
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Hartond MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) write RURAL and give nearest town Havne de Grace Port Veposit filled in by page 15. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? itizen Nursina Home Within YES NO x law requires that the death certificate be executed within 3. NAME OF Middle DATE Last Month Year carban physician and campletely DECEASED Robert Oct. 6 19 Type or print amphe. DEATH SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED please remave last birthday) Months Haurs WIDOWED X DIVORCED au 1Da. USUAL OCCUPATION (Give kind of work dane 1Db. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or fareign country) during most pf working life, even if retired) AH, Perry Point COUNTRY? Marulana 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remaya signed by the attending phy burial-transit permit. Then ampbel Martha Donahoo 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, na, ar unknown) (If yes give war ar dates af service Gertrude Hasson no cremation. CAUSE OF DEATH (Enter only one cause per line INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 'O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital ar attending physician. **DUE TO** Conditions, if ony, which gave rise to immediate couse (a), **DUE TO** stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been far use as the last 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? CERTIFICATION NO 20a. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Hame, farm, (City or town) (County) (Stote) 2Dc. TIME OF INJURY Month, Day, Year Haur a.m. foctory, street, affice bldg., etc.) Nat While at work at work 21. I certify that (1) (this haspital) attended the deceased from 36 M, fram causes and an the date stated above saw the deceased alive an and that death accurred at 220. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR directar, page 3 shauld be filed v M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Port Deposit larence 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) (County) (State) Asbury emetery 24. FUNERAL DIRECTOR 25o. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 1967 Perryville Patterson & Son. DATE OCT Mda

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 3929 CERTIFICATE OF DEATH 13934 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Harford MARYLAND Marvland Harford 24 hours after b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) filled in by Havre de Grace 2 weeks Forest Hill d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? within YES T NO F Citizens Nursing Home 1405 Balsam Place law requires that the death certificate be executed within NAME OF remove corbon First Middle Lost 4. DATE Month Doy Year the ottending physicion and completely sit permit. Then pleose remove carbon DECEASED 67 (Type or print) Clarence Carlisle 19 DEATH October S. SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthdoy) Months Doys Hours ond in any 03-28-1885 WIDOWED K DIVORCED Male White 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Columbus, Ohio USA Retired 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME removal 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service 0 cremation, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), INTERVAL BETWEEN buriol-tronsit PART I. DEATH WAS CAUSED BY ONSET AND DEATH signed by IMMEDIATE CAUSE (o) DUE TO buriol, Conditions, if ony, which gove rise to immediate couse (a). DUE TO oftending | te hos been s use os the b ofth prior to b stoting the underlying couse last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION NO TO FUNERAL DIRECTOR: After this certificate director, page 3 should be detached far us Page 4 may be retained by the hospital or 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH o (IF EITHER, NOTIFY MEDICAL EXAMINER with the State Dept. 20c. TIME OF INJURY Month, Day, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While ot work ot work 21. I certify that (1) (this hospital) attended the deceased from. 196 7, and that death accurred at 44500, fram causes and an the date stated above. saw the deceased alive an 22o. SIGNATUR 22b. DATE SIGNED ATTENDING STAFF PHYS. M.D. PHYS. DIRECTOR director, poge should be filed 22d. ADDRESS 22c. PHYSICIAN NAME (Type 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY BURIAL CREMATION LOCATION (City or Town (County) (Stote) MOVAL (Sched 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66



b. CUTY OF TOWN (if outside corporete limits, write RURA) and give neterest lown) Wife RURAL and give peacest lown) J. RARKE OF C.		DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 13935
d. STREET ADDRESS Control of the	1.	b. CITY OR TOWN (if outside corporate limits, write RURA/and give nearest town) LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURA/and give nearest town)
S. SEX 6. COLOG OR RACE 7, MARRIED 2 NEVER MARRIED 9. DATE OF BIRTH 9. AGE (In year If UNDER 24 HPS. 106. USUAL OCCUPATION (Give kind of work doine duly) which 106. KIND OF BUSINESS OR INDUSTRY 11. STRENGTH 12. CITIZEN OF WHAT COUNTRY 12. CITIZEN OF WHAT COUNTRY 13. TATHER'S NAME 14. MOTHER'S MAINE 14. MOTHER'S MAINE 14. MOTHER'S MAINE 15. WAS DECEASED EVER IN U.S. ARMED FORCES' 16. SOCIAL SECURITY NO. 17. INFORMANT 17. INFORMANT 17. INFORMANT 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c), pare its lo immediate cause 19. Heiling the underlying 19. WAS AUTOPSY PERFORMED! 1	3	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite), give street eddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO Middle Lest 4. DATE Month Dey Yeer
SWAS DECEASED EVER IN U.S. ARMED FORCES 16. SOCIAL SECURITY NO. 17. INFORMANY Address Add		(Type or print) (Itype or pri
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20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.) 20c. TIME OF INJURY Month, Dey, Yeer Hour a.m. p.m. 19 21. I certify that (I) (this hospital) attended the deceased from 19, and that death occurred at AM, from the causes and on the date stated above. 21. I certify that (I) (this hospital) attended the deceased from 19, and that death occurred at AM, from the causes and on the date stated above. 22a. SIGNATURE ATTENDING MED. PHYS. DIRECTOR PHYS. 22b. DATE SIGNED 22c. PHYSICIAN'S 22d. ADDRESS	N.	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e); 19, WAS AUTOPSY
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saw the deceased alive on	MEDICAL	Hour a.m. While Not While fectory, street, office bldg., etc.) p.m. 19 at work et work
ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. SIGNEL 22c. PHYSICIAN'S		21. I certify that (I) (this hospital) attended the deceased from 19, to 19, to 19, that (I) (we) lass saw the deceased alive on 19, and that death occurred at 19, from the causes and on the date stated above.
		ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. SIGNED 22c. PHYSICIAN'S 22d. ADDRESS
	2	PUNERAL DIRECTOR'S SIGNATURE ADDRESS 250. REC'D BY REGISTRAR 286. REGISTRAR'S SIGNATURE



/	MARYLAND STATE DEP	PARTMENT OF HEALTH	
	DIVISION OF VITAL RECORDS, 301 W. PREST Item #3 Film #G394 10/30/	ON STREET, BALTIMORE, MARYLAND 21201	
FOR STATE	13931 MEDICAL EXAMINER'S	CERTIFICATE OF DEATH	13936
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceosed lived, if institution: Re a. STATE b. COUNTY	sidence before admission)
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delay is and 3 ta M3. Page tment af	b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If autside corporate limits, write RURAL one	give nearest town)
ny delu 2, and PM3.	HANTE REGIME	Terry Mar	I DESIDENCE
es 1, darm darm darm	Dad 1/2 + /// - 1/4	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES NO
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 2120 13932 CERTIFICATE OF DEATH 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH npletely filled in by the fune s carbon papers. Pages 1 ar vent, within 72 hours after de OR TOWN (If outside corporate limits, e RURAL and give negree) town) c. CITY OR TOWN It outside corporate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSJITUTION (If not in hospital, give street outress) e. IS RESIDENCE ON A FARM? STREET ADDRESS YES NO requires that the death certificate be executed within NAME OF Middle DATE Month Doy Year DECEASED the attending physician and campletely sit permit. Then please remave carbo OF (Type or print) 12 DEATH 19 67 6. COLOR OR RACE 9. AGE (In years IF LINDER 1 YEAR IF LINDER 24 HRS 7. MARRIED NEVER MARRIED birthdoy) Months Hours WIDOWED DIVORCED KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind of work done 10b. (County & State, or foreign country) 12. CITIZEN OF WHAT during post of working life, everlif retired INDUSTRY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remaya 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? SOCIAL SECURITY NO 17 INFORMANT 275 Address as Reso (Yes, no, or unknown) (If yes give wor or dotes of service 50 crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY toma IMMEDIATE CAUSE (o) DUE TO signed I burial, Conditions, if any, which gave rise to immediate couse (o). DUF TO stating the underlying cause Page 4 may be retained by the haspital ar attending has been the lost. as 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO FUNERAL DIRECTOR: After this certificate p 2Do. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) Hour o.m. Nat While factory, street, affice bldg., etc.) While ot work ot wark . 1967, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. 11.5 1935 . ta 10-12 1967, and that death accurred at 3.00P. M, fram causes and an the date stated above. saw the deceased alive an 10-11 22o. SIGNATURE 22b. DATE SIGNED 10-12-67 directar, page 3 shauld be filed v M.D. DIRECTOR PHYS 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) 230 BURIAL CREMATION, 23d. JOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (Stote) (County) REMOVAL (Specify) 0 BLINERAL DIRECTOR **ADDRESS** 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE DATO C

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH-DEPT. PLACE OF DEATH USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. COUNTYHarford o. STATE Maryland b. COUNTY ecil MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) and Havne de grace town) Port Deposit, Md. d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospitol, give street oddress) d. STREET ADDRESS N. Main Street e. IS RESIDENCE ON A FARM? hours Harford Memorial Hospital Pages NO X YES after deoth. NAME OF 4. DATE Doy Year DECEASED Mariam October 67 Give Dorsey Type or print 19 DEATH 6. COLOR OR RACE 8 DATE OF BIRITY 1969 Sept. 11, 1969 7. MARRIED IF UNDER 1 YEAR IF UNDER 24 HRS. NEVER MARRIED (Dbirthday t emale Months olored Hours Days Item 18. WIDOWED hours event 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) **INDUSTRY** LOUNTRY? Maryland in ony 13. FATHER'S NAMI pencil Richard W. Dorsey, Sr. (D) Thomas E E and Mrs. Elsie Dorsey, 190 N. Main St. 16. SOCIAL SECURITY NO. (Yes, no. or unknown) (If yes give wor or dotes of service) removol. None CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY: 0 IMMEDIATE CAUSE (o) This certificate should writing the ward cremation, DUE TO Hypertensive (V Disease Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse O burial, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? pe prior 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 3 should PRIMARY Or CONTRIBUTING AL EXAMINER: CAUSE OF DEATH 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) foctory, street, office bldg., etc.) may be retoined for yaur FUNERAL DIRECTOR: Page 21. I certify that I took charge of the remains described above, held on Autopsy Inspection and in my apinian Notural causes 1. deoth resulted from: Accident Suicide Homicide Undetermined monner ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY DEPUTY MEDICAL EXAMINER **EXAMINER'S** Palmer, M.D. Gerald Heolth Address (Street, city, town, or county) 230. BURIAL CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 0 REMOVAL (Specify) pres Memorial (emetery 25b. REGISTRAR'S SIGNATURE VR A15ME (5) rson & Son Perruville. 6M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH 13935 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. COUNTY b. COUNTY Harford Maryland MARYLAND Harford requires that the death certificate be executed within 24-hours after b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write_RURAL and give nearest town) 25 Yrs Rural Stewartstown campletely filled in by Stewartstown e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ove corban page event, within 7 YES NO-3. NAME OF First Middle Lost 4. DATE Month Year DECEASED Edie 10/28 19 67 (Type or print) Isabel1 DEATH 8. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED remove last birthdoy) attending physician and ca permit. Then please remov an, ar remaval, and in any Female White Jan.10,1917 WIDOWED DIVORCED 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working lite, even if retired) COUNTRY? INDUSTRY Own Home Pennsylvania 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME John B. Jenkins Lue Lue Lanius IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service Paul H. Edie, Stewartstown RD#1, Pa. None burial, crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: Metastatic Carcinoma INTERVAL BETWEEN the signed by the burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (o) attending physician. DUE TO to Brain and Skeletal system Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been as the Primary Breast Carcinoma WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) CERTIFICATION NO YES O HOSPITAL OR ATTENDING PHYSICIAN: 1 Page 4 may be retained by the hospital ar 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) foctory, street, office bldg., etc.) Not While 21. I certify that (1) (this haspital) attended the deceased fram March saw the deceased glive an 19 , and that death accu 1965, ta Oct. 29, 1967, that (1) (we) last and that death accurred at 750PM, from causes and an the date stated above. saw the deceased alive an 22a SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR director, page 3 should be filed v M.D. PHYS. 22d. ADDRESS Stewartstown, Pa. 22c. PHYSICIAN'S NAME (Type) Reginald B. Gemmill,

23c. NAME OF CEMETERY OR CREMATORY

Oubern, Stewartstown, Pa DATE OCT

Norrisville Cem.

23d. LOCATION (City or Town)

forrisville.

2So. REC'D BY REGISTRAR

(County)

2Sb. REGISTRAR'S SIGNATUR

tord, Md.

(Stote)

23b. DATE THEREOF

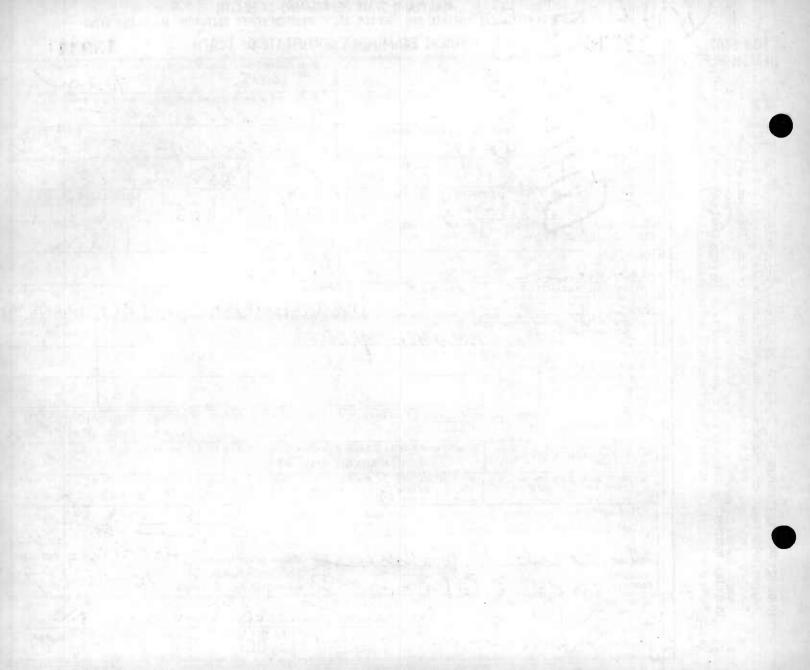
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23o. BURIAL, CREMATION

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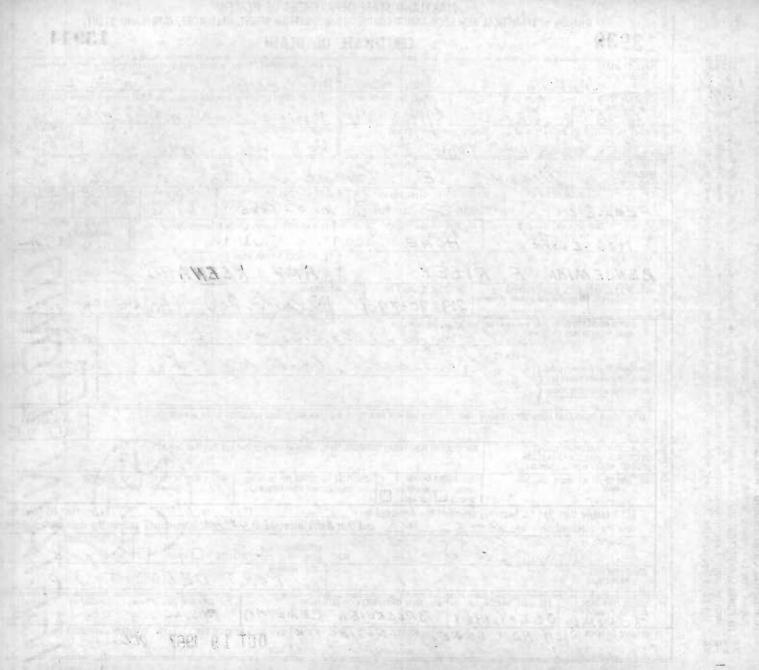
<u> </u>	I	tems 18-21 Film 393 MARYLAND STATE DEPARTMENT OF HEALTH 0-20-67 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 212	201
FOR STATE		13936 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	3941
Page HEALTH DELL	1.	PLACE OF DEATH o. COUNTY H 2 - 4 0 - 4 MARYLAND 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residen o. STATE MARYLAND AMARYLAND	505-d
PM3.	1	b. CITY OR TOWN (If autside corporate limits, write RURAL and give write RURAL ond give neagest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) d. STREET ADDRESS	e nearest town)
after death. If a Sive Pages 1, along with farm with the State De within 72 haurs		356 Bourbonso 356 Bour Dur St	ON A FARM? YES NO
ve Pa ve Pa y with	L	NAME OF DECEASED (Type or print) 1 (1) 3 First B F) e e d lost 4. DATE Manth OF DEATH of the s-	10° 19° 7
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within 24 n pencil in Examiner's File pages 1 and in any	13	FATHER'S NAME 14. MOTHER'S MAIDEN NAME ELDE	7,500
cuted willing in pedical Exar rmit. File	15 (Y-	WAS DECEASED EVER IN U.S. ARMED FORCES? as, no, or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address RELIX FREED 6600 BAY	THORNE RO
should be executed are ward "pending" in the Chief Medical burial-transit permit.		IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), ond (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE (AUSE (a) 104/4/1/4/1/ Poisoning due to sodium	INTERVAL BETWEEN ONSET AND DEATH
hould ward the Ch rrial-tra		Gonditions, if ony, which gove) DUE TO butisol	
ficate ing the ded to ded to as a a f, cre		rise to immediate couse (o). stating the underlying couse last. (c)	
his certi ate, writ e farwar be used to buria	ATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Hypertensive C V disease	19. WAS AUTOPSY PERFORMED? YES NO
INER: The certification of the	L CERTIFICATION	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) Took sleeping tablets	
MEDICAL EXAMINER: alease execute the certi director. Page 4 shauld attended for your files. DIRECTOR: Page 3 shaul s designated agent, pri	MEDICAL	20c. TIME OF INJURY Month, Doy, Yeor Hour o.moct 910 1967 While of work of today, Street office bldg, etc.) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, foctory street office bldg, etc.) Havre de Grace:	1, ,
AL EXA execute ir. Page if far you TOR: Pag		21. I certify that I took charge af the remains described abave, held on Autapsy 🔲, Inspection 🖳 Inquiry	and in my opinion
MEDICAL DIRECTOR DIRE		deoth resulted fram: Notural causes , Accident , Suicide , Homicide , Undetermined manner ACTUAL SIGNATURE ACTUAL SIGNATURE ASSISTANT MEDICAL EXAMINER Be/Aii	22. DATE SIGNED
O DEPUTY MEDICAL EXAM necessary, please execute the funeral directar. Page 4 5 may be retained far your 5 FUNERAL DIRECTOR: Page Health ar its designated age		EXAMINER'S DEPUTY MEDICAL EXAMINER 10-16	0-67
TO DEPUTY necessary, the funeral 5 may be TO FUNERAL Health ar i	230	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town)	(County) (Stote)
VR A15ME (5)	24	FUNERAL DIRECTOR Lewis & Son, INC. ADDRESS CALLED 250. REC'D BY REGISTRAR 250. REGISTRAR'S SI	CALATURE INSIGN



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13945 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. COUNTY Harford o. COUNTY o. STATE MARYLAND Maryland HARFORD
b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b write RURAL and give nearest town) 21050 Forest Hill Forest Hill d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? State | Rigdon Road, Forest Hill, Md. YES T NO X Cooptown Road, Forest Hill 24 hours after death 3. NAME OF 4. DATE Dov DECEASED Give (Type or print) 配lwood DEATH WILLIAM GREENE October 19 67 IF UNDER 24 HRS 7. MARRIED 6. COLOR OR RACE IF UNDER 1 YEAR NEVER MARRIED 8. DATE OF BIRTH AGE (In years lost birthdoy) Months Dovs Hours Item 18. Office WIDOWED DIVORCED 5/29/1933 Colored dea and 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY U.S.A. Mechanic Madonna, Maryland Auto. Chief Medical Examiner's 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME be executed within Annie Marie Smith Jacob Aquilla Greene WAS DECEASED EVER IN U.S. ARMED FORCES? MIT SHEORMANT 16. SOCIAL SECURITY NO. Box 653 (Yes, no, or unknown) (If yes give wor or dotes of service) within 212-30-7611 Glenda L. Greene Forest Hill. Md. No 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) INTERVAL RETWEEN burial-transit PART I. DEATH WAS CAUSED BY event ONSET AND DEATH Shotgun wound of the abdomen IMMEDIATE CAUSE (o) _ certificate should the ward DUE TO any Conditions, if ony, which gove p rise to immediate cause (o), = DUE TO stoting the underlying couse and PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) remaval, 19. WAS AUTOPSY PERFORMED? certificate. YES X NO 20o. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) shauld crematian, ar CAUSE OF DEATH Shot with shotgun in the abdomen 2Dc. TIME OF INJURY Month, Doy, Year (City or town) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (Stote) Hour om While foctory, street, office bldg., etc.) Not While While of work of work Uncle's vard please execute Forest Hill Harford Md. 21. I certify that I taok charge of the remains described above, held an Autapsy Inspection . Inquiry , and in my apinion burial, death resulted fram: Natural causes . Accident . Suicide , Hamicide x Undetermined manner may be retained CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior FUNERAL DEPUTY MEDICAL EXAMINER **EXAMINER'S** NAME (Type) Address (Street, city, town, or county) Edward F. Wilson, M.D.

23c. NAME OF CEMETERY OR CREMATORY October 9, 196 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) 50 Burial Burial 10/12/1967 Fairview A.M.E. Forest Hill, Harford Md PECID-BY REGISTRAR 967 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS VR ATSME Jarrettsville, Md. Charles E. Kurtz 6M 1/67 21084

Charles . The state of the s CET HOLD DESK, HOLDEN H. A., MI. e le s terror la serie de fronte de la restación de la restaci Mind street strak 212-34-7511 There b. Greene corest Elli. Md. in the inclusion of the inclusion. The line and all religious lists to the - Harring at the same of the s and the second second Senial 10/17/1967 Salrving L. S. S. S. Strong Hill, Himsond Her haries, i. Edria Jurrettaville, 94. | Old II (1884) - Francisco

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 3941 CERTIFICATE OF DEATH 24 hours after death funeral 1 and and I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY MARYLAND c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If autside carparate limits, c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest tawn) write RURAL and give nearest tawn) filled in by d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? within 72 h remove carban papers NO S YES law requires that the death certificate be executed within 3. NAME OF 4. DATE Year the attending physician and campletely isit permit. Then please remove carban DECEASED OF DEATH (Type or print) 190 S. SEX IF UNDER I YEAR IF UNDER 24 HRS. 6. COLOR OR RACE AGE AGE (In years last birthdoy) 7. MARRIED NEVER MARRIED Manths DIVORCED and in any WIDOWED 10b. KIND OF BUSINESS OR THPLACE (County & State, ar foreign country) INDUSTRY during most of working life, even if ret 13. FATHER'S MOTHER'S MAIDEN NAME 17. INFORMAN WAS DECEASED EVER IN U. SCARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no or anknown) (If yes give war or dotes of service) crematian, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: burial-transit IMMEDIATE CAUSE (a) signed by attending physician. DUE TO burial Canditions, if any, which gove rise to immediate cause (a), DUE TO stoting the underlying cause TO FUNERAL DIRECTOR: After this certificate has been as the WAS AUTOPSY PERSORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION of Health NO the haspital ar detached far 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (City or town) (County) (State) Hour a.m. factory, street, affice bldg., etc.) Not While ot wark TO HOSPITAL OR ATTENDIN Page 4 may be retained by 21. I certify that (1) (this haspital) attended the deceased fram 10 - 16 1967, ta 10 __, 1967, that (I) (we) last shauld and that death accurred at 11 30 M, fram causes and an the date stated above. saw the deceased alive an_ 10 22o. SIGNATURE STAFF PHYS. M.D. DIRECTOR PHYS directar, page shauld be filed filed 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) q 6 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City or Jown) 23a. BURIAL, CREMATION 23b. DATE THEREOF (County) ap7isi ridge K 250. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 75b. VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13947 CERTIFICATE OF DEATH 3942 deoth. low requires that the death certificate be executed within 24 hours after death puo 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) the funerol PLACE OF DEATH a. COUNTY a. STATE b. COUNTY MARYLAND c. LENGTH OF STAYAN 16 c. CITY OR ZOVAN (If autside carparate limits, write RURAL and give neorest town) CITY OR TOWN write RURAL and dive neares town clay.S 00 Frace perdee d. STREET DDRESS d. NAME OF HOSPITAL OR INSCITUTION (If not in haspital, give street address) IS RESIDENCE ON A FARM NO YES moria NAME OF DATE Day Year signed by the attending physicion and campletely buriol-transit permit. Then please remove carbor DECEASED 19 DEATH (Type ar print IF UNDER 24 HR IF UNDER 1 YEAR 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH birthday Manths Haurs June WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind af wark dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during mast af warking life, even if retired) Home COUNTRY ? Housewife 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Frances A. Knight omas WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16. SOCIAL SECURITY NO. (Yes, no, ar unknawn) (If yes give war ar dates af service) 216-28-3554 Miles W. Welsh. Aberdeen. Maryland cremation, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) ONSET AND DEAT PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) be retained by the hospital or attending physician. DUE TO AKCINOWATES 19 Canditians, if any, which gave rise ta immediate cause (a). DUE TO stating the underlying cause TO FUNERAL DIRECTOR: After this certificate hos been os the last. WAS AUTOPSY PERFORMED? DISEASE CONDITION GIVEN IN PART 1(a) OTHER SIGNIFICANT, CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL CERTIFICATION YES NO for 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, 20f. (City ar tawn) (Caunty) (State) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED factory, street, affice blda., etc.) Haur a.m. Nat While certify that (Mithis haspital) attended the deceased fram . ta shauld and that death accurred at AM, fram causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 22a. SIGNATURE **ATTENDING** DIRECTOR PHYS. PHYS M.D. **ADDRESS** 22c. PHYSICIAN'S NAME (Type) director, should b 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY (State) 23b. DATE THEREOF (Caunty) BURIAL, CREMATION REMOVAL (Specify)
Bur 1a1 Oct. 67 16 Bakers Cemetery Aberdeen Harford Md. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR DATE 20 M 1 Tarring Home Funeral Aberdeen. Md

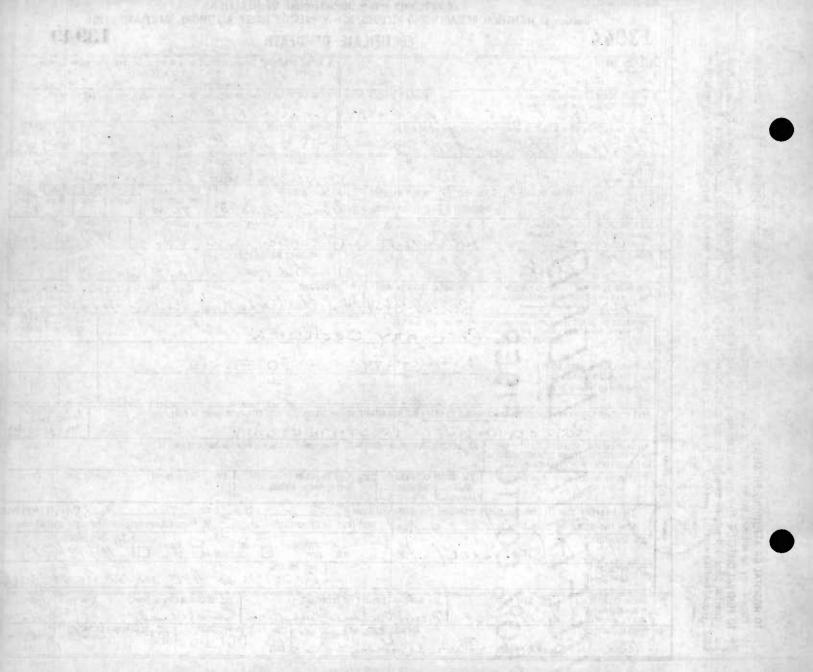
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13948 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. STATE b. COUNTY o. COUNTY MARYLAND c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) papers. Pa e. IS RESIDENCE ON A FARM? d. STREET ADDITESS d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) 3 09 YES NO NAME OF Middle DATE Month Doy Year remave carbon First Last attending physician and campletely permit. Then please remave carbon DECEASED OF DEATH 6 Atherine 19 (Type ar print) IF UNDER 24 HRS AGE (In years IF UNDER S. SEX 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH NEVER MARRIED last birthday) Months Days Haurs WIDOWED DIVORCED Negro 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind aflwark done 11. BIRTHPLACE (County & State, or foreign country) during most of working life_even if retired) INDUSTRY miss , Dood Hanile 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME INFORMANT Address WAS DECEASED EVER IN U.S. ARMED FORCES? permit. (Yes, no or unknown) (If yes give wor or dotes of service) -9303 Mr. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: erebral IMMEDIATE CAUSE (a) signed by DUE TO burial Conditions, if ony, which gave rise to immediate cause (a), DUE TO stating the underlying couse be retained by the haspital ar attending as the priar tal TO FUNERAL DIRECTOR: After this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) use Health 1 CERTIFICATION NO P 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a, ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (Stote) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Manth, Day, Year factory, street, affice bldg., etc.) Haur o.m. Not While 19 at work at wark pe 21. I certify that (I) (this haspital) attended the deceased fram Oct 26 1967 to OCT 26, 1967, that (I) (we) last shauld 2-6 1967, and that death accurred at 5 A M, from causes and an the date stated above saw the deceased alive on_ CT 22b. DATE SIGNED 220. SIGNATURE ATTENDING MED. DIRECTOR × M.D. PHYS. PHYS. director, page shauld be filed TO HOSPITAL (Page 4 may b 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 569 Kevolution St. Haure de Girace, M Jeorde I 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 23a. BURIAL, CREMATION DATE INTEREOF (County) REMOVAL (Specify) REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 2Sh. SUNERAL DIRECTOR Misseles VR A15 (4) 20 M 1/66 1967

The Board of the State of the S DE AMERICA STATEMENT DE LA CAMBILLA DEL CAMBILLA DE LA CAMBILLA DEL CAMBILLA DE LA CAMBILLA DE L The same of the sa

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13944 13949 CERTIFICATE OF DEATH 24 haurs after death and 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH a. COUNTY b COUNTY MARYLAND c. LENGTH OF STAY IN 1b c. CLTY OR TOWN (If guts/de carparate limits, write RURAL and give nearest tawn) CITY OR TOWN (If outside corporate limits, write RURAL and give negrest/fown bon papers. within 72 ha .⊑ d. STREET ADDRESS e. IS RESIDENC d. MAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street oddress ON A FARM illed YES NAME OF Middle 4. DATE Month Day Year remaye carbon completely DECEASED OF (Type or print) event, DEATH requires that the death certificate be executed DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Months Days Hours and in any WIDOWED DIVORCED the attending physician and sit permit. Then please rem KIND OF BUSINESS OR 12. CITIZEN OF WHAT 1Da. USUAL OCCUPATION (Give kind at wark dane 10b. 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remaval, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service crematian, 1B. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY ORONARY IMMEDIATE CAUSE (a) signed by DUE TO burial HYPOTENSION Conditions, if ony, which gove (b) rise to immediate couse (a). DUE TO stating the underlying couse as the Page 4 may be retained by the haspital ar attending this certificate has been lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) far use Health NO TRUSTATECTOMY. DERATIVE 2Dg. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH af 3 shauld be detached with the State Dent of (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (State) 20c, TIME OF INJURY Month, Doy, Year 2Df. Hour a.m. factory, street, affice bldg., etc.) Nat While 19 at wark O FUNERAL DIRECTOR: After at wark 21. I certify that (1) (this haspital) attended the deceased fram Z, and that death occurred at S.M, from causes and an the date stated abave saw the deceased alive_on 10 22b. DATE SIGNED 22a. SIGNATURE MED. **ATTENDING** STAFF PHYS. M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S 611 SO, UNION AVE HAVRE NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (State REMOVAL (Specify) es Juneal Jone 25a. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) DATE

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. COUNTY Harford a. COUNTY Harford Maryland MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) Rural - Darlington rural Darlington 51 years 12 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET AODRESS e. IS RESIDENCE lease remove carbon papers and in any event, within 72 ON A FARM? NO X YES completely executed within First Laura 3. NAME OF Middle Last Month Day Year DECEASED 28 October 19 67 Wirginia Knight Virginia (Type or print) DEATH 5. SEX 6. COLOR OR RACE AGE (In years | IFUNDER 1YEAR | IFUNDER 24HRS. | Iast birthday) | Months | Days | Hours | Min. 8. DATE OF BIRTH 7. MARRIED A NEVER MARRIED Female White June 23.1916 WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewiie 12. CITIZEN OF WHAT COUNTRY? 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) physician certificate be INDUSTRY Harford Co., Md. U.S.A. or removal, 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ifter this certificate has been signed by the attending be detached for use as the burial-transit permit. The State Dept. of Health prior to burial, cremation, or remov Samuel M. Orr Emmaline Reynolds 15. WAS OECEASEO EVER IN U.S. ARMEO FORCES?
(Yes, no, or unkown) \ (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT death Kloman Knight. Darlington, Md. 162-05-9414 INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),] PHYSICIAN: The law requires that the the hospital or attending physician. PART I. DEATH WAS CAUSED BY: Pulmonary Embolism immediate IMMEDIATE CAUSE (a) **OUE TO** Phlebothrombosis.rt.leg / weeks. Conditions, If any, which (b) gave rise to immediate **OUE TO** cause (a), stating the underlying cause last. CERTIFICATION WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO A YES 20a. ACCIDENT WAS UNDERLYING OESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. O FUNERAL DIRECTOR: After director, page 3 should be d should be filed with the State Not While OR ATTENDING F at work at work Jan. 24 Oct.28 21. I certify that (I) (this hospital) attended the deceased from. and that death occurred at 11AM, from the causes and on the date stated above. saw the deceased alive on 22b. DATE SIGNED 22a. SIGNATURE -ATTENDING MED. DIRECTOR STAFF PHYS. Oct. 28/67 Page 4 may t PHYS. PHYSICIAN'S 22d. ADDRESS Robert Barthel M.D. Box #4. NAME (Type) Forest Hill, Md., 21050 BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23d. LOCATION (City, town or county) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 31.1967 Broad Creek Friends Street, Harford Co., Md. 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR Delta. Pa. VR A15 (4) 15M 4-64

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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		PLACE OF DEATH	MARVIAND	2. USUAL RESIDENCE (Where deceased lived, if in o. STATE May De b	nstitution: Residence befare admission)
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	L	write RURAL and dive nearest fown)	2/ days	Have de Gra	ul 12-1
6	8	I NAME OF HOSPITAL OR INSTITUTION (If not in	haspital, give street address)	d. STREET ADDRESS 848 Olecas	e. IS RESIDENCE ON A FARM? YES NO
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	duri	USUAL OCCUPATION (Give kind of work done ng mass of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. DETTIPLACE (County & Stote, or foreign country)	12. CITIZEN OF WHAT COUNTRY A
	13.	FATHER'S NAME Oleceral		14. MOTHER'S MAIDEN NAME	
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		rise to immediate cause (a), stating the underlying cause last.	Chemia		4 diego
3	ATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTR		HE TERMINAL DISEASE CONDITION GIVEN IN PART I	PERFORMED?
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		21. I certify that (1) (this haspite saw the deceased alive an Oc	al) attended the deceased fram		uses and an the date stated above.
		22a. SIGNATURE CMM L. WA	lover M.D	A	22b. DATE SIGNED /0/11/67
		22c. PHYSICIAN'S NAME (Type)		22d, ADDRESS	//
	_	(BURIAL CREMATION, REMOVAL (Specify) 23b. DATE THEREO	67 MX. Eur	1 Sand	June Md
	/24.	FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR 1967 25	Sb. REGISTRAR'S SIGNATURE
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director, should VR A15 (4) 20 M 1/66

24 FUNERAL DIRECTOR

DATE THEREOF

NAME (Type)

23a. BURIAL, CREMATION,

REMOVAL (Specify)

HOPE W **ADDRESS**

23c. NAME OF CEMETERY OR CREMATORY Cem.

2So. REC'D BY REGISTRAR

DOSI 2Sb.

13950

IS RESIDENCE ON A FARM?

Year

IF UNDER 24 HRS.

19

Hours

INTERVAL BETWEEN

ONSET AND DEATH

WAS AUTOPSY PERFORMED?

NO

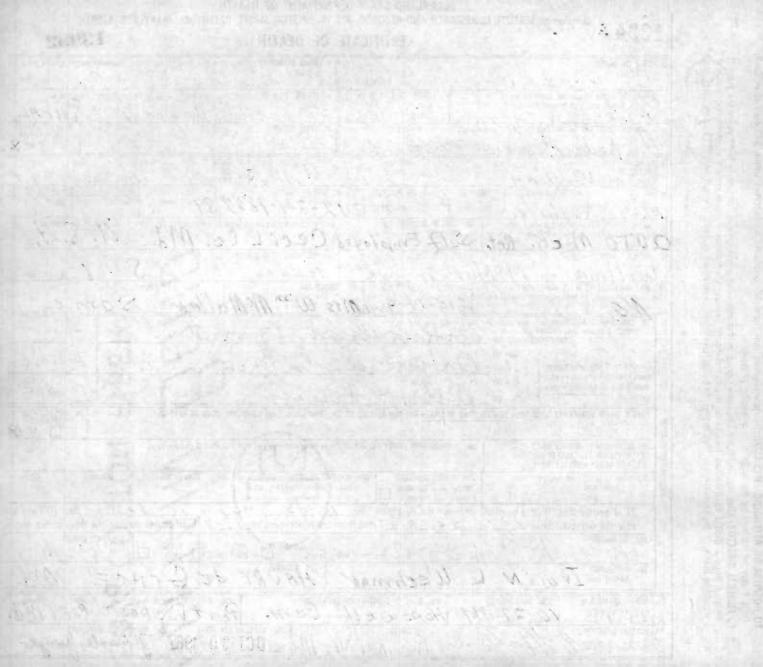
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13953 CERTIFICATE OF DEATH death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b COUNTY MARYLAND requires that the death certificate be executed within 24 hours after borr papers. Pages 1 within 12 haurs afte b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town = e. IS RESIDENCE d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ON A FARM? filled Route NO X Box 138 YES NAME OF Middle DATE Lost Doy Year the attending physician and completely sit permit. Then please remave carbon DECEASED C 19 (Type or print) DEATH S. SEX IF LINDER 1 YEAR IF LINDER 24 HRS 6. COLOR OR RACE DATE OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED Loss birthdoy) Months Dovs Hours 1888 20 Oct. DIVORCED and in any WIDOWED 10o. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired)
Storekeeper INDUSTRY COUNTRY? Harford County Md. General Store S .A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remaval. Samuel Bryson Mitchell Alice Virginia Wakeland 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dotes of service 17. INFORMANT Address 16. SOCIAL SECURITY NO. 36-7528 Wife Yes Same as burial, crematian, INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH (Enter only one couse per signed by the burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse prior to b has been use as the lost. WAS AUTOPS)
PERFORMEO? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) State Dept. of Health CERTIFICATION NO this certificate far 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. foctory, street, office bldg., etc.) Not While ot work O FUNERAL DIRECTOR: After 21. I certify that (I) (this haspital) attended the deceased from 19___, that (I) (we) last pluads and that death occurred at M. fram causes and an the date stated above. saw the deceased alive and 22b. DATE SIGNED ATTENOING DIRECTOR M.D. PHYS PHYSICIAN" ADDRESS NAME (Type) director, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) Calvary Meth. Cemetery REMOVAL (Specify) Churchville, Maryland Oct. 6 Buzra Home 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR 196 VR A15 (4) 20 M 1/66 inchberdeen.

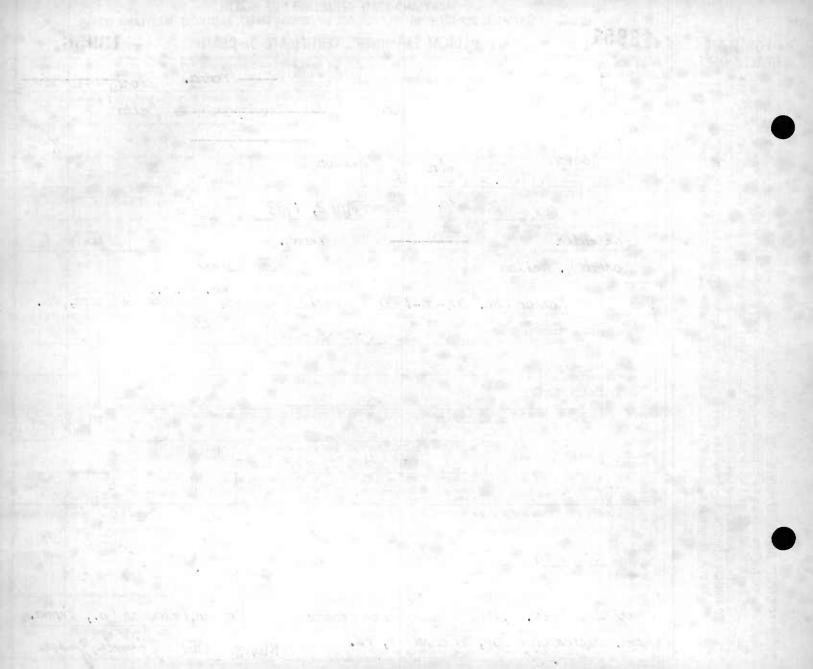
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13955 CERTIFICATE OF DEATH by the funeral Pages 1 and 2 24 hours after death 2. USUAL RESIDENCE (Whene deceased lived, if institution: Residence before admission) PLACE OF DEATH a. COUNTY a. STATE h COUNTY MARYLAND artor c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If autside carparete limits, c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) write RURAL and give nearest flown TRACE d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) d. STREET ADDRESS ON A FARM YES NO TE law requires that the death certificate be executed within 3. NAME OF DATE Last Day Year DECEASED (Type or print) ontgomera DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE NEVER MARRIED last birthdoy) 60 yrs. Months Hours Dec. 22.1906 WIOOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during most of warking life, even if retired) INDUSTRY Barber COUNTRY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ontaumeru orence 16. SOCIAL SECURITY NO 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na or unknown) (If yes give war ar dates af service 200-10-4234 Mrs. Cecile E. Montgomery, Elkton, Mo INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one cause per line fot (a), (b), and (c).) buriol-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) signed by DUE TO Canditians, if ony, which gave rise to immediate cause (a), DUE TO stating the underlying cause Hazs O FUNERAL DIRECTOR: After this certificate hos been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO X 10 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II af item 18.) 20a. ACCIDENT/WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (Stote) 20c. TIME OF INJURY Month, Day, Yeor factory, street, office bldg., etc.) Hour o.m. Nat While 10 - 2, 1967, that (1) (we) lost 21. I certify that (I) (this haspital) attended the deceased fram. 2 19 67, and that death occurred at 928M, from causes and on the date stated above. sow the deceased olive on. 22b. DATE SIGNED 22a. SIGNATIBRE ATTENDING PHYS. M.O. **OIRECTOR** PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, should b 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or town) (Stote) 23a. BURIAL, CREMATION 23b. DATE THEREOF (County) PEMOYAL Specify) Cemetery, Colora. West Nottingham Pres. AD DRESS 2Sq. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Funerals, Elkton, Md. DATE OCT 9

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 3951 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY b. county ork Page delay is and 3 ta af death. partment c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, autside carparate limits. write RURAL and give nearest tawn and P.M3. after e. IS RESIDENCE ON A FARM? INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS 72 hours State NO in Item 18. Give Pages 24 haurs after death. Office alang with NAME OF Neclon Lost 4. DATE Month Day Year ohm DECEASED with the Tope 050 within 19 (Type or print) DEATH S SEX AGE (In years 6. COLOR OR RACE NEVER MARRIED 8. DATÉ OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Manths Days Haurs May 2, 1933 WIDOWED DIVORCED l and 2 event 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT 1Da. USUAL OCCUPATION (Give kind of work done during mast of working life even if retired) INDUSTRY COUNTRY Penna. any Examiner's pages in any 14. MOTHER'S MAIDEN NAME Nora Powers 13. FATHER'S NAME within pencil Joseph G. Neilon File and 17. INFORMANTHANLOND Mem Hospadress Havre de Grace, Md. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. be executed permit. (Yesyan, arunknawn) (If yes give war ar dates of service) remayal "pending" Hospital Records 18. CAUSE OF DEATH (Enter only one cause per lipe for (a), (b), and (c).) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: ar IMMEDIATE CAUSE (a) shauld writing the ward crematian, DUE TO Canditians, if any, which gave rise to immediate cause (a) DUE TO This certificate D stating the underlying cause OS burial, nsed 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO please execute the certificate. designated agent, priar ta 2Do. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW_INJURY OCCURRED. (Enter nature of injury in Part II or Part II of item 18.) 3 shauld PRIMARY, ar CONTRIBUTING MEDICAL EXAMINER: CAUSE OF DEATH MEDICAL 2Dc. TIME OF INJURY Manth, Day, Year 2De. PLACE OF INJURY (Hame, farm, (County) (State) factory, street, affice bldg., etc.) A/ Mour a.m. Nat While 1.to FUNERAL DIRECTOR: Page at wark far 21. I certify that I took charge of the remains described above, held on Autopsy Inspection and in my opinion Accident K the funeral directar. death resulted from: Suicide Natural causes Homicide Undetermined manner may be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE TO DEPUTY necessary, DEPUTY MEDICAL EXAMINER 0 Health NAME (Type Address (Street, city, tawn, ar caunty) 50 Penna. (emeteru leadon, Delaware (o., (ross 2Sb. REGISTRAR'S SIGNATURE 2Sq. REC'D BY REGISTRAR VR A15ME (5) 1967 DANOV



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2057		13958
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write RURAL gnd give nearest town) AURCOL GRACE 31 hRS.	HAUREde GRACE	d give neorest town)
HARFORD MEMORIAL HOSP, TAL	107 PARKWAY AVE	YES NO
DECEASED (Type or print) BEVERLY ARNETTE OWE	en Of DEATH October	29 1967
FEMALE WIDOWED DIVORCED D	10-28-67 lost birthdoy) Mon	NDER 1 YEAR IF UNDER 24 HRS. One of the state of the sta
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STEPHEN EARL OWENS	CARROLL ANN WALKE	R
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE	E TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19. WAS AUTOPSY PERFORMED? YES NO
	nter noture of injury in Port I or Port II of item 18.)	
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 29d. INJURY OCCURRED While Not While of work of work		(County) (Stote)
21. I certify that (I) (this haspital) attended the deceased fram Oct 39 1967, and that a	of 36, 1961, to Oct 39, death accurred of 125 PM, from causes and	19 67 that (I) (we) la an the date stated obov
220. SIGNATURE LE MON DE DOMCUM.D.	ATTENDING MED. STAFF C	2b. DATE SIGNED 10 24/67
22c. PHYSICIÁN'S NAME (Type)	22d. ADDIRESS	/ / '
30. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CR. REMOVAL (Specify) OCT, 50, 1967 ANGEL HILL	CEM. HAVREDEGRAC	
24. FUNERAL DIRECTOR Mitchell, Havre de Grace	Mo- DATE OCT 3 1 1967 ACC	AR'S SIGNATURE
	Division of STATISTICAL RESEARCH AND RECORDS, 301 CERTIFICATE PLACE OF DEATH O. COUNTY AND COUNTY D. CITY OR TOWN (If outside corporote limits, write RURAL and give negres) town) A. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) A. NAME OF DECEASED Citype or print) BEVER AND ARKIED DIVORCED DIVORCED DIVORCED 10. USUAL OCCUPATION (Give kind of work done luring most of working life, even if refired) 11. EATHER'S NAME TEPHEN EARL OWENS 12. WINDUSTRY 13. FATHER'S NAME TEPHEN EARL OWENS 14. CAUSE OF DEATH (Enter only one couse per line for (e), (b), ond (g).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), storing the underlying couse lost. OR CONTRIBUTING CAUSE OF DEATH (If ETIHER, NOTHEY MASOLAL EXAMINER) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OTHER CONTRIBUTING CAUSE OF DEATH (If ETIHER, NOTHEY MOSTICAL EXAMINER) 20. TIME OF INJURY Month, Doy, Yeor Hour o.m. 19 of work of otwork of work done While Not While forcer 10. SOW the deceased drive on Contributing of order of work of	PLACE OF DEATH O. COUNTY O. STATE O. COUNTY O. COUNTY O. STATE O. COUNTY O. STATE O. COUNTY O. STATE O. COUNTY O. STATE O. STATE O. STATE O. STATE O. COUNTY O. STATE O. COUNTY O. STATE O. COUNTY O. STATE O. STATE O. STATE O. STATE O. STATE O. COUNTY O. STATE O. COUNTY O. STATE O. COUNTY O. STATE O. S

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Division of STA	MARYLAND STATE DEP TISTICAL RESEARCH AND RECORDS, 301	PARTMENT OF HEALTH W. PRESTON STREET, BALTII	MORE, MARYLAND 21201
13953	CERTIFICATE	OF DEATH	13959
1. PLACE OF DEATH HOR !	FORD. MARYLAND	2. USUAL RESIDENCE (Where deceose o. STATE	ed lived, if institution: Residence before odmission b. COUNTY
b. CITY OR TOWN (If outside corporate) write RURAL and give decrest town)	race 10hrs.	FERRY	te limits, write RURAL and give neorest town)
d Name of Hospital or Institution (RIAL HOSPITAL	d. STREET ADDRESS RIVE	R. R. Box 425 e. IS RESIDENCE ON A FARM?
3. NAME OF DECEASED (Type or print)	Tha made a	Lost 4. DATE OF DEATH DATE OF BIRTH 9.	Month Doy Year 19/17 AGE (In years IFUNDER 1 YEAR IF UNDER 24 HRS.
S. SEX 6. COLOR OR RACE	WIDOWED DIVORCED	5-2-1904 11. BIRTHPLACE (County & Stote, or for	lost birthdoy) Months Doys Hours Min.
100. USUAL OCCUPATION (Give kind of work d during mort of working life, even if retired)	INDUSTRY	14. MOTHER'S MAIDEN NAME	COUNTRY
15. WAS DECEASED EVER IN U.S. ARMED FOR	M 6055.	NEORMANT JAC	Le Laddreys
(Yes, no, or unknown) (If yes give wor or do	tes of service) Unknown	Betty h. Da	ggalecryville, Md.
PART I. DEATH WAS CAUSED BY: IMMEDIATE CA	1036 (0)	daie	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if ony, which gove rise to immediate couse (o),	DUE TO Perferenced where	- + Peritom	tis 4 hours
last.	(c) Ac. Peptro alcer NS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE	HE TERMINAL DISEASE CONDITION GIVE	N IN PART 1(0) 19. WAS AUTOPSY PERFORMED?
200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING OR CONTRIB	20b. DESCRIBE HOW INJURY OCCURRED. (YES NO X
		E OF INJURY (Home, form, 20f.	(City or town) (County) (Stote)
Hour o.m.	19 While of work of work haspital) attended the deceased fram	ory, street, office bldg., etc.)	a Oct 27, 1967 that (1) (we) las
saw the deceased alive at 220. SIGNATURE	n_0ct 27_1967, and that	death accurred at 42PN	A, fram causes and an the date stated above
22c. PHYSICIAN'S NAME (Type) 3 / 1 . A / 7	D. ATIL M.D	ATTENDING MED. DIRECTOR 22d ADDRESS	STAFF 10-28-411
400/1/	E THEREOF 23c. NAME OF CEMETERY OR C	REMATORY 23d. 19	CATION (Eity or Town) (County) (Stote)
24. FUNERAL DIRECTOR	30-1967 Belder Memo	250. REC'D BY REGISTR	- need of 10 series
M Nell y laster	am & my lectresiels	DATKOV 2	1967 Tillaries Jones

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

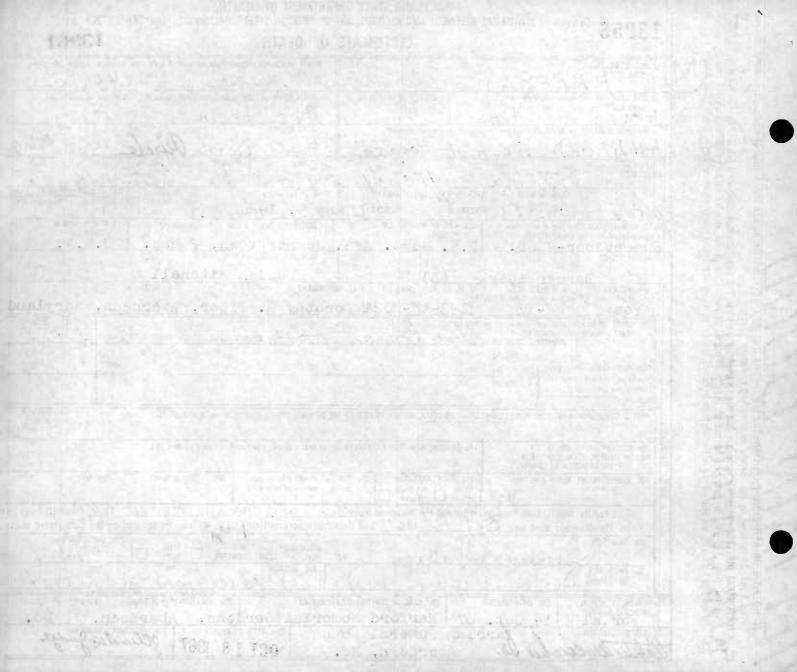
Litem 3 Film Gasart OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY Hafford MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest tawn)
Havne de Grace d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS ON A FARM Citizen Nursing Home, 415 S. Market St. YES NAME OF Middle First 4. DATE remave carbon Lost Month Doy Year OF DECEASED Lillie B. Oct. 67 Ovens (Type or print) Owens 19 DEATH S. SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH NEVER MARRIED lost birthdoy) Months Hours Female 03-28-1885 WIDOWED IK DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? the attending physician sit permit. Then please Maryland Housewife USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME duin L Sarah L. Wilson 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dotes of service) Unknown Ruth O. Knauss, Port Deposit, Maryland, NTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o) (b), ond (c).
PART I. DEATH WAS CAUSED BY: burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) signed by attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse as the O FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY ed far use a PERFORMED? YES NO 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING (CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Not While ot work 21. I certify that (I) (this haspital) attended the deceased fram. 1967, and that death occurred of 430 M, from causes and an the date stated above saw the deceased olive on 22o. SIGNATURE 22b. DATE SIGNED DIRECTOR M.D. director, page 3 shauld be filed 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) larence I. Benson 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) VR A15 (4) 20 M 1/66 Patterson & erruville

MARYLAND STATE DEPARTMENT OF HEALTH

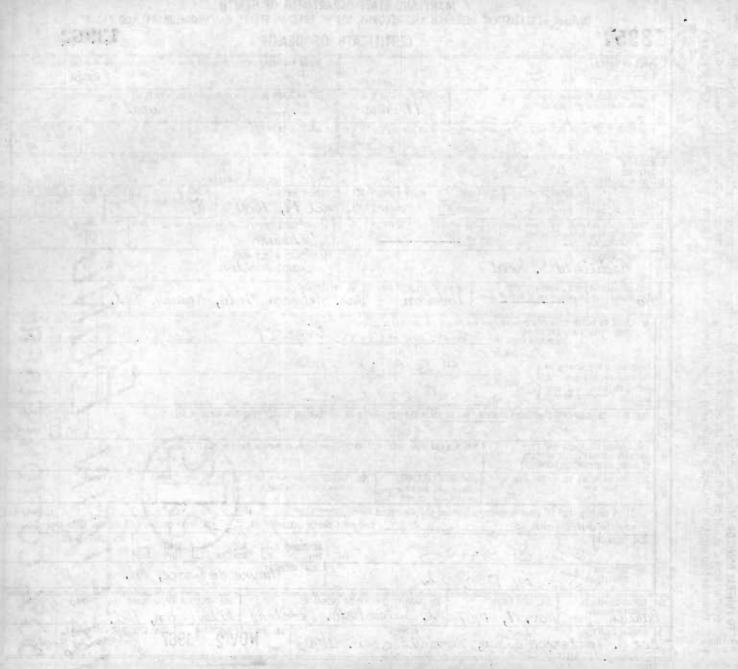
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The pool suggest of the Town Town Street State Lanner ... an Armorean ... Level ... To Tolland etc. T. C. II. Water Street taffecto emiliand IV and the state of t 2N-W-42W N-ELLOW, St. Company St. official legith in the factor of the factor Tente Company Willy Merculus Dr. Autoriana 12.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13961 CERTIFICATE OF DEATH 24 hours after death death pup 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) the funeral PLACE OF DEATH a. COUNTY o. STATE COUNTY after. MARYLAND Pages CITY OR TOWN (If autside corporate limits, c LENGTH OF STAY IN 1b autside Larparate limits, write RURAL and give nearest tawn write RURAL and give nearest tawn). popers. d. STREET ADDRESS IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street oddress) NO X YES The law requires that the death certificate be executed within MMdle DATE NAME OF Day Year First Last carbar DECEASED 19 (DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS AGE (In years S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH please remave last birthday) Days Hours DIVORCED May WIDOWED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or fareign country) during most af working life, even if retired) INDUSTRY COUNTRY? Jennerstown, Penna. Supervisor-ESSD Govt 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Beulah Mitchell Piper 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, na, ar unknawn) (If yes give war ar dates of service) Dorothy B. Piper, Aberdeen, Yes crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per ling for ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by **DUE TO** burial Canditians, if ony, which gave rise to immediate cause (a), DUE TO stating the underlying cause as the priar ta TO FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) use NO YES P ATTENDING PHYSICIAN: far 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (State) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City ar town) (County) 20c. TIME OF INJURY Manth, Day, Year foctory, street, office bldg., etc.) Not While at work be retained by pe 21. I certify that (1) (this haspital) attended the deceased fram June 12 1967, ta 007/6, 1967 that (1) (we) last shauld 1967, and that death accurred at 125 M, fram causes and an the date stated above saw the deceased alive an_ 22b. DATE SIGNED 22o. SIGNATURE ATTENDING DIRECTOR PHYS. M.D. PHYS. be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) directar, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 23o. BURIAL, CREMATION, REMOVAL (Specify) Harford Memorial Gardens. Aberdeen. Md. arring Funewal **FUNERAL DIRECTOR** Home Aberdeen. Md. 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death 24 haurs after death pup 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY a. STATE b. COUNTY ecil MARYLAND by the c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits write RURAL and give nearest town days Rural OULS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? carban pape and completely filled NO X YES within The law requires that the death certificate be executed within 3. NAME OF 4. DATE Last Month Doy Year DECEASED 00 1967 DEATH (Type ar print) IF UNDER 1 YEAR 9. AGE (In years IF UNDER 24 HRS. SEX DATE OF BIRTH 6. COLOR OR RACE 7 MARRIED NEVER MARRIED PC remave Manths birthday) Haurs Dovs Horil DIVORCED WIDOWED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT please during most of warking life, even if retired) **INDUSTRY** COUNTRY? Delaware 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME remayal Archibald S. Reed Sara Fulton 16. SOCIAL SECURITY NO. 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (YesAplo or unknown) ((If yes give wor or dates of service) Mrs. Rebecca Pinto, Newark, Del. Unknown INTERVAL BETWEE 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) signed by DUE TO burial Conditions, if any, which gave rise ta immediate couse (o), DUF TO stating the underlying couse the hospital ar attending priar tal as the O FUNERAL DIRECTOR: After this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED 🕡 THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) USe NO V YES Jo 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City ar town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, Not While foctory, street, office bldg., etc.) at wark at wark pe be retained by 196) to Oct 21. I certify that (1) (this hospital) attended the deceased fram. 19 67, and that death occurred at 200 M, from couses and on the date stated above 10-29 saw the deceased alive an 220. SIGNATUR 22b. DATE SIGNED ATTENDING M.D. DIRECTOR PHYS. PHYS. director, page should be filed 22d. ADDRESS Havne de Grace, Md. 22c. PHYSICIAN NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) (County) (State) 23a. BURIAL, CREMATION, 23b. DATE THEREOF BUREMOVAL (Specify) Mt. Salem Meth. emeteru Wilmington. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Marie VR A15 (4) 20 M 1/66

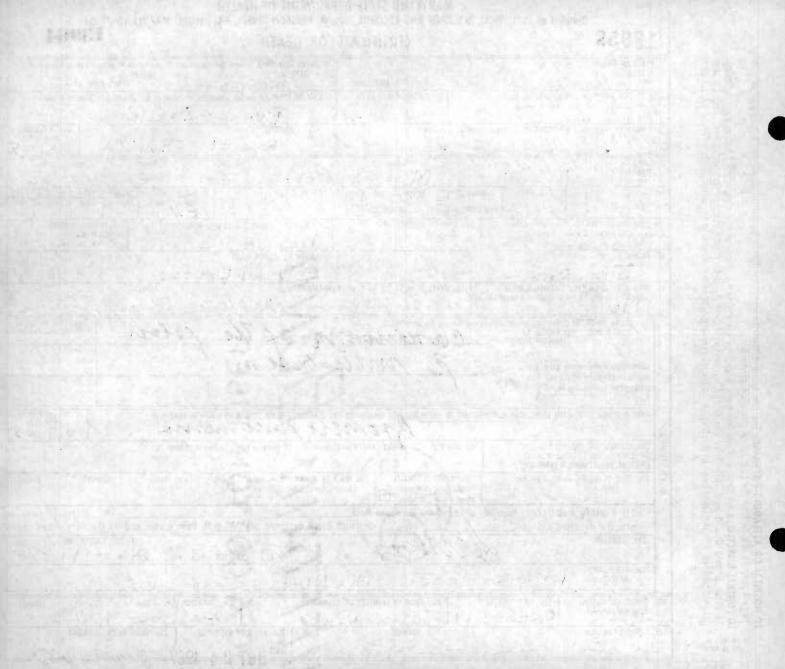


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 3958 CERTIFICATE OF DEATH law requires that the death certificate be executed within 24 hours after death funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission o. COUNTY o. STATE b. COUNTY in by the Pages 1 MARYLAND c. CITY, OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest town) ve carbon papers. Pag event, within 72 hours e. IS RESIDENCE ON A FARM? NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRES YES NO X NAME OF Middle DATE Month Doy Year physician and campletely DECEASED 19 Type or print) DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS DATE OF BIRTH 6 COLOR OR RACE 7. MARRIED NEVER MARRIED please remave lost birthdoy) Months Hours and in any WIDOWED DIVORCED 17. BIRTHPLACE (County & Store, or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY Coming during most of working-life, even if retired) COUNTRY? Hoving Solu serry mon 13. FATHER'S NAME MOTHER'S MAIDEN NAME or remaya signed by the attending phy 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service) -907 crematian, 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) by the haspital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO has been s stoting the underlying couse as the last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION Health NO X this certificate far 20b. DESCRIBE HOW INJURY OCCURRED. (Enter-nature of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. factory, street, office bldg., etc.) Not While O FUNERAL DIRECTOR: After ot work 21. I certify that (I) (this hospitol) attended the deceased from 1967, ta 10/11 , 1967, that (I) (we) last be retained shauld 1967, and that death occurred at 6:550 M, from causes and on the date stated obove saw the deceased alive an 10/10 22b. DATE SIGNED 22o. SIGNATURE **ATTENDING** DIRECTOR PHYS. M.D. PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Xech b directar, shauld 23d. LOCATION (City or Town) 23b. DATE THEREOF NAME OF CEMETERY OR CREMATOR (Stote) 23o. BURIAL, CREMATION, 23c. (County) REMOVAL (Specify) acodestlemeter 2So. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS 2Sb. 20 M 1/66

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 133964 13959 CERTIFICATE OF DEATH virthin 72 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. COUNTY o. STATE b. COUNTY MARYLAND ARFORD filled in by the c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) b. CITY OR TOWN (If ourside corporate limits. 24 hours aft write RURAL and give nearest town ARLINGTON d. STREET ADDRESS e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ON A FARM? R.D. YES NO X requires that the death certificate be executed within NAME OF 4. DATE carban Middle Doy Year Lost the attending physician and campletely sit permit. Then please remove carban DECEASED 19 6 owan (Type or print DEATH IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX B. DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthdoy) Months Dovs Hours and in any WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, eyen if retired) INDUSTRY 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME removal ITTLE ORR WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no olunknown) (If yes give wor or dotes of service 0 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) signed by Page 4 may be retained by the haspital ar attending physician. DUE TO burial, Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been use as the prior to lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION directar, page 3 should be detached tar use shauld be filed with the State Dept. af Health mmumonna NO YES 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or town) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (County) (Stote) Not While factory, street, office bldg., etc.) 21. I certify that (I) (this hospital) attended the deceased from 19 , 19___, that (I) (we) last . ta ond that death occurred at \\\ M, from causes and on the date stated obove. saw the deceased olive an_ 22o. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. STAFF PHYS. 750 M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 1. LATOS HAVRE DE GRACE 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (Stote) 23o. BURIAL CREMATION. EMOVAL (Specify) ARLINGTON MOTSHLIMA 2So. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

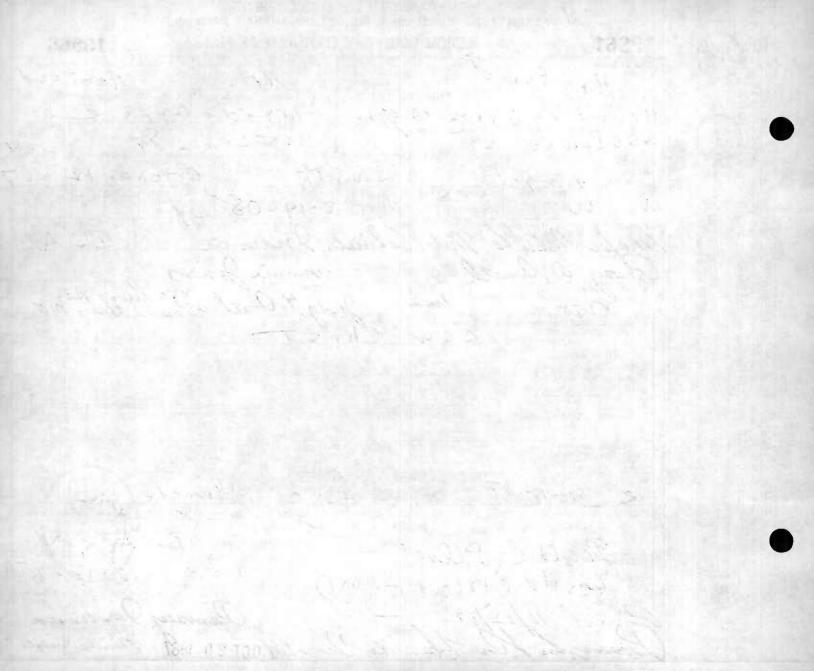


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 3950 13965 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY 0 MARYLAND delay 50 b. CITY OR TOWN c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carparate limits outside carparate limits, write RORAL and give negrest tawn partme ond PM3. write RURAL and give neorest town d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET AOORESS IS RESIDENC farm ON A FARM? pencil in Item 18. Give Pages 1, Stote NO IX YES be executed within 24 hours ofter deoth. Office olang with 3. NAME OF DATE Middle First Lost Month Doy Year OECEASED OF DEATH with the (Type or print) Octobe S SEX IF LINOER 1 YEAR IF UNOER 6. COLOR-OR RA 7. MARRIED DATE AGE (In veors NEVER MARRIEO lost birthday) Months Dovs Hours event within 72 hours ofter death WIDOWED DIVORCED ond 2 10o. USUAL OCCUPATION (Give kind of work done 10b. KINO OF BUSINESS OR (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INOUSTRY COUNTRY? pages 10 word "pending" in pencil in the Chief Medical Examiner's Garage Owner TOTAGO 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME File USSe IS. WAS DECEASED EVER IN U.S. ARMED FORCES 17. INFORMANT 16. SOCIAL SECURITY NO. Address permit. F (Yes, no, or unknown) (If yes give wor or dotes of service) 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN buriol-tronsit PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) CAL EXAMINER: This certificote should writing the word DHE TO ony Conditions, if ony, which gove rise to immediate couse (o), 0 2 **OUE TO** stoting the underlying couse 0 farworded puo lost. as 19. WAS AUTOPSY PERFORMED? or removol, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) necessary, please execute the certificate, NO P pe 4 should be 20g. EXTERNAL CAUSE WAS 20b. OESCRIBE HOW INJURY OCCURREO. (Enter nature af injury in Port 1 or Port 11 of item 1B.) 3 should PRIMARY Or CONTRIBUTING CAUSE OF DEATH. cremotion, MEDICAL 20c. TIME OF INJURY Manth, Ooy, Year 20d INJURY OCCURREO 20e, PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Your Not While FUNERAL DIRECTOR: Page Page 4 ot work at wark 21. I certify that I taak charge of the remains described above, held an Autopsy Inquiry De Inspection A and in my opinion burial, the funeral director. Natural causes TX deoth resulted fram: Accident Suicide Homicide Undetermined monner be retoined CHIEF MEDICAL EXAMINER 0 22. DATE SIGNEO ACTUAL ASSISTANT MEDICAL EXAMINER prior SIGNATURE O DEPUTY DEPUTY MEDICAL EXAMINER **EXAMINER'S** Heolth NAME (Type) Address (Street, city, town, or county) may 23o. BURIAL, CREMATION DATE THEREOF NAME OF CEMETERY OR CREMATORY 23c. 23d. LOCATION (City or Town (Stote) (County) 0 REMOVAL (Specify) 4) FUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATUR VR A15ME (5) 196 DATE NOV 6M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

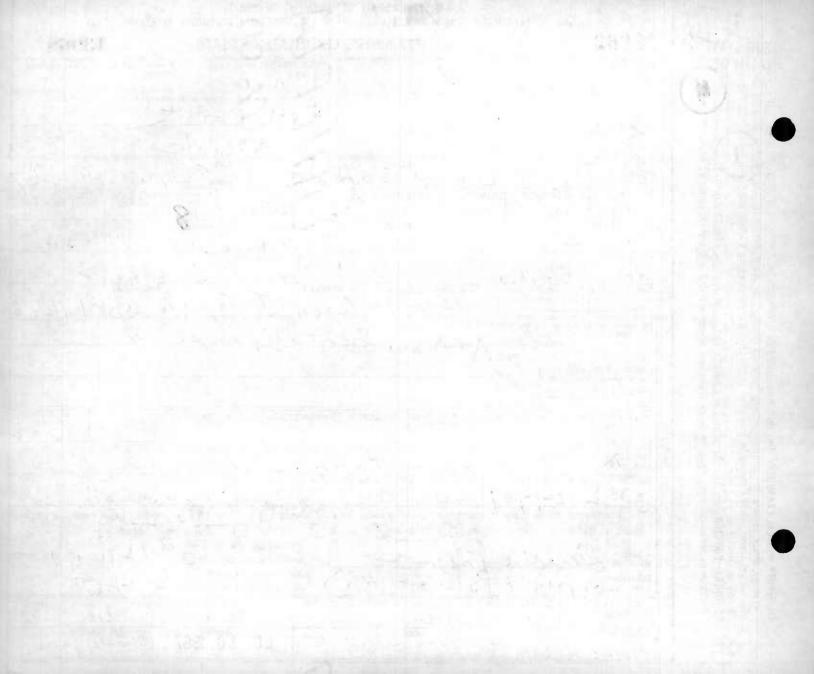
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-, VR A15ME (5)		24	FUNERAL DIRECTOR	ADDRESS	2Sa. REC'D BY REGISTRAR	b. REGISTRAR'S SIGNATURE
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH Harford o. STATE Marvland a. COUNTY b. COUNTY Harford impletely firled in by the fur ve carbon papers. Pages 1 event, within 22 hours after MARYLAND c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b write RURAL and give nearest tawn) Fallston Fallston d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? (10) NO V YES requires that the death certificate be executed within 3. NAME OF Middle 4. DATE First Last Year please remave carbon the attending physician and completely sit permit. Then please remave carbon DECEASED DEATH (Type or print) GRANVILLE HAROLD SPENCER October 9. AGE (In years IF UNDER 1 YEAR S. SEX 8. DATE OF BIRTH IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED irthdoy) Manths Dovs Hours May 6, 1912 and in any White DIVORCED Male 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of warking life, even if retired) Glenn L. Virginia Carpenter Martin 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME ar remaval, Granville Spencer Polly Ann 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no or unknown) (If yes give wor or dates of service Wm. I. Spencer, Box 56, Fallston, Md. 21047 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) signed by the burial-transit p CARDIO-RESPIRATORY FAILURE ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital ar attending physician. DUE TO MASSIUF CORONARY OCCLUSION burial, Canditions, if any, which gove MINEDIATE rise to immediate couse (a), CORONARY 1960 DUE TO stating the underlying cause FUNERAL DIRECTOR: After this certificate has been as the last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION of Health NO YES far 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER the State Dept. (City or town) (County) (Stote) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, Hour a.m. foctory, street, office bldq., etc.) Not While 197 p, to 31000 21. I certify that (I) (this haspital) attended the deceased fram. 19.67 that (I) (we) last 1951 1967, and that death accurred at M, fram causes and an the date stated above. saw the deceased glive an 3100T 22b. DATE SIGNED 22a. SIGNATURE **ATTENDING** MD DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S P. Sidwell, MD Bel Air, Maryland NAME (Type) Harvey director, shauld be 23b. DATE THEREOF 11/3/1967 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) 23o. BURIAL, CREMATION, (County) Bel Air Memorial Gardens Bel Air, Harford Co. Md. BENOVAL (STecify) 9 ADDRESS Maryland 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE Coules Tarring Funeral Home, Aberdeen 1967 DATE NOV

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 963 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Page 0 MARYLAND delay and 3 b. CITY OR TOWN outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) P.M.3. write RURAL and give nearest town) INSTITUTION (If nat in hospital, give street oddress) IS RESIDENC hours ON A FARM? NO after death. NAME OF within 72 Month Year. DECEASED (Type or print DEATH 19 alang with DATE OF BIRTH IF UNDER 24 HRS 7. MARRIED NEVER MARRIED irthdoy) Months Item 18. Doys Hours event WIDOWED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY pages 1 in any Examiner's This certificate shauld be executed within pencil 13. FATHER'S NAME File and WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT permit. the certificate, writing the ward "pending" i 4 shauld be farwarded ta the Chief Medical (Yes, na, or unknown) ((If yes give wor or dates af service) removal. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED 8Y Б please execute the certificate, writing the ward burial, crematian, DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse О lost. used (PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? NO. YES pe 10 20o. EXTERNAL CAUSE WAS PRIMARY TO OF CONTRIBUTING ☐ CAUSE OF DEATH. priar 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) 3 should O DEPUTY MEDICAL EXAMINER: MEDICAL agent, 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (City or town) (Home, form, (County Stote Not While foctory, street, office bldg., etc.) FUNERAL DIRECTOR: Page ot work designated of the remains described above, held an Autapsy Inspection and in my apinian the funeral director. death resulted fram Suicide be retained Hamicide Undetermined manner CHIEF MEDICAL EXAMINER DATE SIGNED SIGNATURE 10 DEPUTY MEDICAL EXAMINER Health NAME (Type) Address (Street, city, town, or county) **8URIAL CREMATION** DATE THEREO NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 0 REMOVAL (Specify) FUNERAL DIRECTOR REGISTRAR'S SIGNATURE VR A15ME (5)



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13969 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY 2, and 3 to PM3. Poge o. STATE b. COUNTY Harford of Maryland Harford MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town)

Havre de Grace CLENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) after Aberdean d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? hours Harford Memorial Hospital 34 W. Bel Air Ave. Give Pages YES NOTES after death. 3. NAME OF First Middle 4. DATE Month Lost Doy DECEASED ANNIE YARNELL TARRING October 2. 67 DEATH phong IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED Y DATE OF BIRTH 9. AGE (In years NEVER MARRIED birthdoy) Item 18. Hours Female White WIDOWED DIVORCED puo 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Perryman, Maryland II.S.A. poges in any Housewife

13. FATHER'S NAME Home 14. MOTHER'S MAIDEN NAME be executed within Harriet Malcolm Jasper Peter Yarnell pup 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) ((If yes give wor or dotes of service) cremotion, or removol, H. Willard Tarring, Aberdeen, Md. 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH + 80.40 1º IMMEDIATE CAUSE (o) certificote should word DUE TO forworded to the Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO the certificate. its designoted ogent, prior to 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.) PRIMARY For CONTRIBUTING CAUSE OF DEATH. 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) foctory, street, office bldg., etc.) moy be retoined for your FUNERAL DIRECTOR: Page ot work 21. I certify that I taak charge of the remains described above, held an Autopsy [Inspection X Inquiry X ond in my opinian Accident 🔼 the funerol directar. death resulted from: Homicide T Undetermined manner Natural causes Suicide CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER **EXAMINER'S** Gerald C. Palmer, M.D. 5 moy 100 FONER Address (Street, city, town, or county) Bel Air. Marvland NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) Oct. 67 Spesutia Cemetery Perryman. Harford Md. arring Fune Fune VR A15ME Aberdeen, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13965 CERTIFICATE OF DEATH 24 hours after deoth puo 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) funeral PLACE OF DEATH o. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (If autside carparate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) popers. e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS Med YES NOVY low requires that the death certificate be executed within NAME OF Middle DATE Manth Year Last Doy carbon the attending physicion and completely sit permit. Then please remove carbor DECEASED OF vring DEATH 19 (Type or print) DATE OF BIRTH AGE (In years IF UNDER YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE NEVER MARRIED 7. MARRIED remove lost birthday) Hours WIDOWED DIVORCED Dec. 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Ret 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) **INDUSTRY** Aberdeen. Maryland Broker & Salesman Canned Goods 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Brokerage Hannah Elizabeth Greenland Tarring Henry WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, no, grunknown) Tarring Jr. Havre de Grace. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c),) buriol-tronsit PART I. DEATH WAS CAUSED BY ONSET AND DEAT IMMEDIATE CAUSE (o) signed by ottending physician. DUE TO Conditions, if ony, which gove rise to immediate cause (a), DUE TO stating the underlying couse os the TO FUNERAL DIRECTOR: After this certificate has been WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO X the hospital or for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 1B.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or tawn) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Haur a.m. factory, street, affice bldg., etc.) Nat While at work be retained by 21. I certify that (1) (this hospital) attended the deceased fram there 1962 1957, that (1) (we) last . ta. should and that death accurred at 1 00 M, fram causes and an the date stated above. saw the deceased glive an Oct. 22b. DATE SIGNED. 22o. SIGNATURE STAFF PHYS. M.D. DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S Plunkett NAME (Type) M.D. Bel Air Ave. Aberdeen, Md. director, 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 23b. DATE THEREOF (County) 23a. BURIAL, CREMATION, REMOVAL (Specify) 18 Oct. 67 Spesutia Cemetery Perryman (Harford) Md. 2Sa. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR Tarring 1981 Home VR A15 (4) 20 M 1/66 Aberdeen. Md. DATE

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TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funest director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death 24 hours after TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

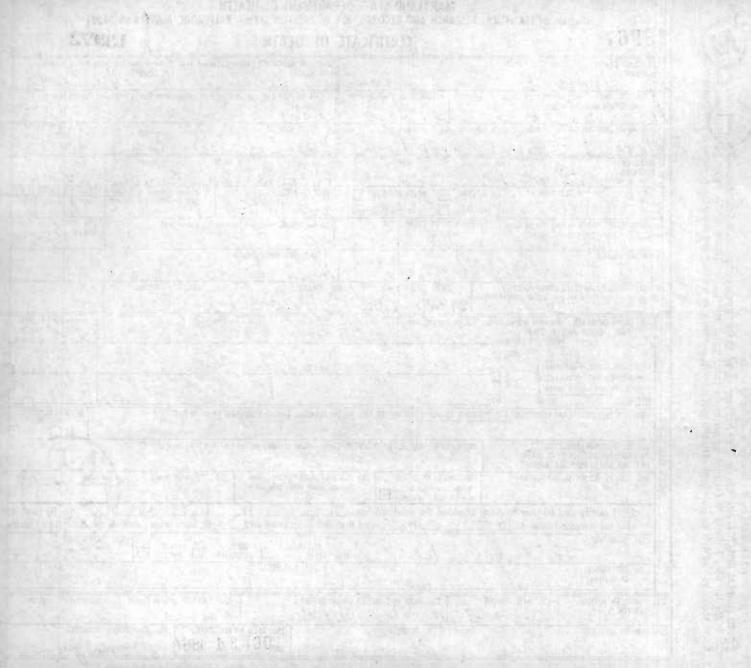
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5.	SEX	6. COLOR OR RACE	7. MARRIE	D NEVER MARRIE	D	B. DATE OF BIRTH	9. A	SE (In years I st birthday)	FUNDER 1 YEAR Months Days	Hours Min.
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10a	a. USUAL OCCUPAT	ION (Give kind of work ing life, even if retire	done 10b.	KIND OF BUSINESS O	R	11. BIRTHPLACE (County & State, or	foreign country)	12. CITIZEN COUNTR	OF WHAT
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	Floyd L.	Tucker				Mary Eliz	abeth New	rsone		
15	. WAS DECEASED	EVER IN U.S. ARMED FO	RCES? 1	6. SOCIAL SECURITY N	0. 17.	INFORMANT		Address	S	
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CERTIFICATION	20a. ACCIDENT OR CONTRIBUT (IF EITHER, NO	WAS UNDERLYING ING CAUSE OF DEATIFY MEDICAL EXAMI	TH NER) 20b.	DESCRIBE HOW INJU	JRY OCCU	RRED. (Enter nature		-p.C%		
MEDICAL	20c. TIME OF Hour a.t			INJURY OCCURRED Not While at work	20e. PLA facto	CE OF INJURY (Home, ry, street, office bldg.,		y or town)	(County)	(State)
	21. I certif	fy that (t) (this hos	oital) atter	nded the deceased	from_2	7 SEP	1967 to 1	O OCT	_, 19_67, t	hat (I) (v) last
		ceased alive on 1		19 67	and that	death occurred at	1050 PM, from	the causes a	and on the da	te stated above.
	22a. SIGNATU		z.	Rote	M.C	ATTENDING D	MED. DIRECTOR	STAFF PHYS.	22b. DATE S	Cr 67
	22c. PHYSICIA NAME (T	lani	A. RO	TH, CPT, MC		22d. ADDRESS KIRK ARM	Y HOSPITA	L, ABER	DEEN PG	, MD.
23	a. BURIAL, CREM REMOVAL (Sp	MATION, 23b. DATE	THEREOF	23c. NAME OF C		OR CREMATORY			wn or county)	(State)
	Burial	Oct.16	,1967		Nat:	ional Cemet	ery Ft.	Myer.	Va .	NATURE
	4. FUNERAL DIR			ADDRESS			EC'D BY REGISTR		- 0	
H	oward K.	McComas & !	Son. A	hingdon. Md	- 27	009 DATE	OCT 16	1967	Munico	y Judge

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 3967 CERTIFICATE OF DEATH 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY ARFORd MARYLAND CITY OR TOWN (If outside carporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) write RURAL and give negrest town) e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS ON A FARM? dod YES NO P within requires that the death certificate be executed within please remove carbon NAME OF DATE Doy Lost Year the ottending physicion and completely sit permit. Then please remove carbon DECEASED OF DEATH (Type or print) 19 SEX IF UNDER 1 YEAR 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED last birthday) Months Days Haurs and in any WIDOWED DIVORCED 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) during most of working life, exen-if, retired) INDUSTRY COUNTRY? 13. FATHER'S NAME MOTHER'S MAIDEN NAME or removal, 16. SOCIAL SECURITY NO. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates af service CAUSE OF DEATH (Enter only one cause per line (b), and (c). INTERVAL BETWEEN buriol-tronsit PART I. DEATH WAS CAUSED BY ONSET AND DEAT signed by IMMEDIATE CAUSE (a) Page 4 moy be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by DUE TO buriol Conditions, if any, which gave rise to immediate couse (a). DUE TO stating the underlying couse as the last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) CERTIFICATION for use with the Stote Dept. of Health NO X YES 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTLEY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) detached 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (Stote) 20c. TIME OF INJURY Manth, Day, Year (County) foctory, street, office bldg., etc.) Hour a.m. Nat While 19 at work at work 21. I certify that (I) (this haspital) attended the deceased fram Oct 19 1.7, to Oct. 2 plnous and that death accurred at 10 40 M, from causes and an the date stated abave saw the deceased alive an Oct 22a. SIGNATURE > 22b. DATE SIGNED **ATTENDING** STAFF PHYS. director, page 3 should be filed v M.D. PHYS. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) VICE 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY. 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) mountain Juria 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 1967

MARYLAND STATE DEPARTMENT OF HEALTH



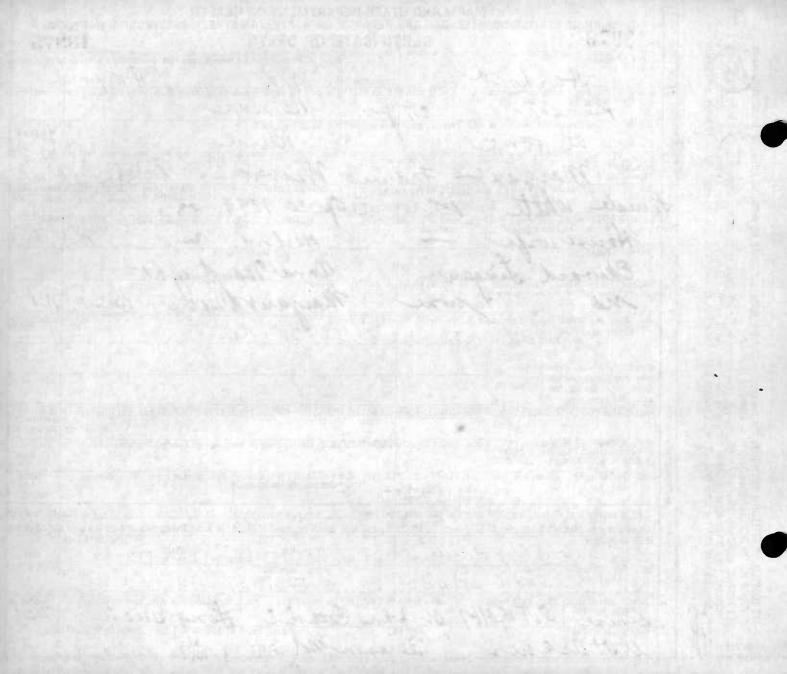
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH within 24 hours after death by the funeral Pages 1 and 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY b. COUNTY o. STATE MARYLAND Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest tawn) **Iifetime** Edgewood - Rural gewood IS RESIDENCE ON A FARM? physician and completely filled in d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS within 72 h YES NO X none 3. NAME OF please remave carbon Middle 4. DATE First Last Manth Day Year DECEASED OF TSABELLE WATTERS October 19 (Type or print) DEATH PHYSICIAN: The law requires that the death certificate be executed S. SEX 9. AGE (In years IF UNDER YEAR IF UNDER 24 HRS. B. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthdoy) Months Haurs April 2, 1919 Female and in any Negro WIDOWED DIVORCED 10a, USUAL OCCUPATION (Give kind of wark dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY **COUNTRY?** Harford Co., Maryland home 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or remayal, Unknown Alice Watters IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address Md. permit. (Yes, na, or unknown) (If yes give war or dotes of service) Elsie Mae Demby, 2066 Battle St., Edgewood 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) signed by the haspital ar attending physician. terril scloritu heart disease with Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying cause Page 4 may be retained by the haspital ar attending to FUNERAL DIRECTOR: After this certificate has been be detached far use as the State Dept. af Health priar ta 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CERTIFICATION 1 month at NO Sc YES 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20e. PLACE OF INJURY (Home, farm, (County) (Stote) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED factory, street, office bldg., etc.) Not While 19 at work at work 21. I certify that (I) (this haspital) attended the deceased fram 2-10 , 1965, ta 10-13, 1967, that (1) (we) last 1927, and that death accurred at A. M., from causes and an the date stated above. saw the deceased alive an_ 10-12. 22o. SIGNATURE 22b. DATE SIGNED Oct.13, 1967 M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Edgewood, Maryland Fred O. Hodous. M.D. directar, shauld 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) 23a. BURIAL, CREMATION, (County) REMOVAL (Specify) Community Baptist Cemeter Joppa Rumal 2Sq. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 ocharles Howard K. McComas & Son, Abingdon, Md.

DATE OCT

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE DF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY MARYLAND b. CITY DR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) hours .= d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled e. IS RESIDENCE d. STREET ADDRESS ON A FARM? in any event, within NO YES completely i 3. NAME OF First Middle DATE Month Day Year 4. DECEASED OF (Type or print) DEATH 196 executed 5. SEX 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS and cor 8. 7. MARRIED NÉVER MARRIED last birthday) Months Hours 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT physician 11. BIRTHPLACE (County & State, or foreign country) lease and ir during most of working life, even if retired) INDUSTRY certificate be COUNTRY? or removal, FATHER'S NAME MOTHER'S MAIDEN NAME attending phermit. Then 15. WAS DECEASED EVER IN U.S. ARMED FDRCES! 16. SOCIAL SECURITY NO. 17. INFORMANT Address **DIRECTOR:** After this certificate has been signed by the attenage 3 should be detached for use as the burial-transit permit. Filed with the State Dept. of Health prior to burial, cremation, or death (Yes, no, or unkown) (If yes give war or dates of service) CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **OR ATTENDING PHYSICIAN:** The law requires that the retained by the hospital or attending physician. DUE TO Conditions, if any, which (b) gave rise to Immediate DUE TO (a), stating the underlying cause last (c) CERTIFICATION 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES IM NO T 2Da. ACCIDENT WAS UNDERLYING I 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part 11 of Item 18.) DR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) TIME DF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. Not While at work at work 1960 to Oct 14 21. I certify that (I) (this hospital) attended the deceased from July , 1967, that (I) (we) last 1967, and that death occurred at 4 A M, from the causes and on the date stated above. saw the deceased alive on 22a. SIGNATURE 22b. DATE SIGNED page : ATTENDING DIRECTOR Page 4 may 1 M.D. PHYS. PHYS FUNERAL PHYSICIAN'S 22d. ADDRESS 22c. director, p NAME (Type) OU W00 NAME OF CEMETERY OR CREMATORY (State) 23a. BURIAL, CREMATION, 23b DATE THEREOF 23c. 23d. LOCATION (City, town or county) 9 REMOVAL (Specify) 24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 4-64



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Page Harford Maryland and 3 to af Harford MARYLAND delay ortment o deal b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) offer Aberdeen Havre D.O.A. de Grace d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? Harford Memorial Hospital Route Box YES NO X pencil in Item 18. Give Pages after death. NAME OF Middle 4. DATE Lost Day Year Office alang with DECEASED the 67 ARCHIE WILEY J. October 19 (Type or print) DEATH within IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Months Hours Days Caucasian WIDOWED DIVORCED Sept. 1916 24 haurs event 2 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) COUNTRY? during most of working life, even if retired) **INDUSTRY** W. Va. any pages in any Soldier U.S. Army 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME be executed within Ferrell John Marion File and WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT (Yes, na, ar unknown) (If yes give war or dates af service) ar removal, 235-18-9088 Aberdeen, Maryland. Yes Current INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) This certificate should icate, writing the ward be farwarded ta the C crematian, DUE TO Canditians, if any, which gave rise ta immediate cause (a), DUE TO stating the underlying cause burial, 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CERTIFICATION NO please execute the certificate, designated agent, prior ta pe 20g. EXTERNAL CAUSE WAS PRIMARY Dor CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 1B.) shauld AL EXAMINER: Auto--Train accident. 20e. PLACE OF INJURY (Home, farm, MI trocker Syee, Affice add. Dec. O (City or town) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED (County) YOUF FUNERAL DIRECTOR: Page of work Aberdeen-Har. aspenska crossing Md. at work 21. I certify that I taak charge of the remains described above, held an Autopsy \(\preceq\). Inspection X and in my opinian may be retained far Inquiry X the funeral director. death resulted fram: Notural causes Accident to Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL or its ASSISTANT MEDICAL EXAMINER SIGNATURE necessary, DEPUTY MEDICAL EXAMINER **EXAMINER'S** Gerald C. Palmer, Health o Address (Street, city, town, or county) Bel Air. NAME (Type) 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 50 Burial (Specify) Hanfond Memorial Gardens Aberdeer
ADDRESS 250. REC'D BY REGISTRAR 25
Penning 1/e Md. DATE OCT 23 1967 24. FUNERAL DIRECTOR Lee A. Patterson & Soh, Perryville, Md. VR A15ME (5)

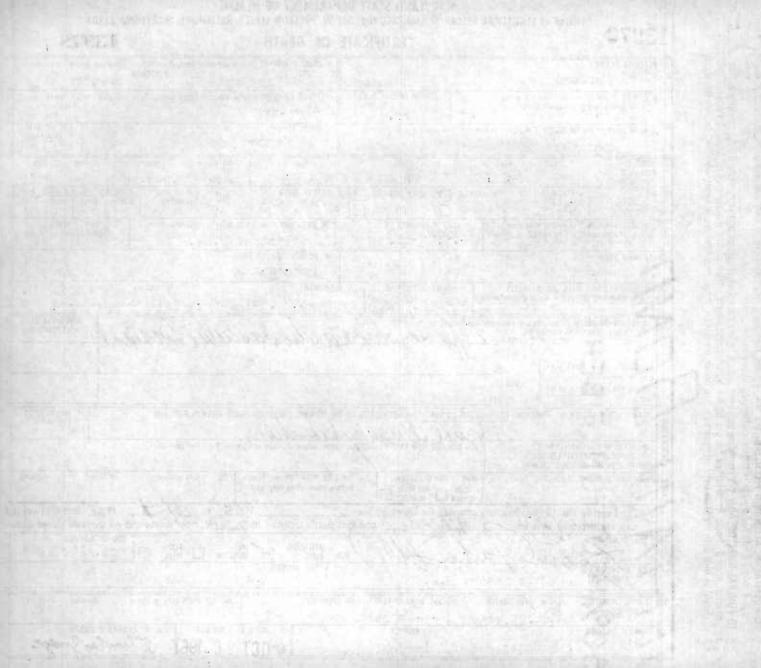
MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13977 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STAT HEALTH DEP 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY delay is and 3 ta M3. Page MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 1b pup P.M3. write RURAL and give nearest town) 1900 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS in pencil in Item 18. Give Pages 1, form ON A FARM? NO This certificate should be executed within 24 haurs after deoth. alang with NAME OF Doy Year DECEASED OF DEATH OCT (Type or print) S. SEX 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH AGE (In years NEVER MARRIED lost birthdoy) Months Doys ile pages land2 w haurs after death. WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done Bainoridge N.T. during most of warking life, even if retired) Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Alexander Williams Margretta Pitts permit. File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, 14 or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO 17. INFORMANT event within 72 Chief Medical Mrs. Margretta Williams, Port Deposit, Md. 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN enital Heart Disease ONSET AND DEATH **burial-transit** PART I. DEATH WAS CAUSED BY: DUE TO farwarded ta the any Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse 19. WAS AUTOPSY PERFORMED? removal, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO pe 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 3 should 0 PRIMARY Or CONTRIBUTING CAUSE OF DEATH. crematian, MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Not While ot work ot work 21. I certify that I taok charge of the remains described above, held an Autapsy Inspection . Inquiry X and in my apinian Natural causes Accident Suicide [death resulted fram: Hamicide Undetermined monner 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER Health prior DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county) 23d. LOCATION (City or Town) 0 Bureal (Specify) okesbury Meth. Port Deposit, 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15ME (5) Lee A. Patterson & Son, Perryville, DATE NOV

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13978 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Harford Harford ampletely filled in by the fur ve carban papers. Pages 1 event, within 22 boars after MARYLAND c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest tawn) 哥 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) 24 hours Edgewood Vrs. e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? 1911 Hanson Road 00 NO 3 none YES requires that the death certificate be executed within Middle 4. DATE please remave carban NAME OF Firs1 Month Doy Year the attending physician and campletely sit permit. Then please remave carban DECEASED SHIRLEY October MASON WILLTAMS 19 67 DEATH (Type or print S. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In veors 7. MARRIED **NEVER MARRIED** birthdoy) Months Doys Hours Female White May 27, 1908 and in any WIDOWED DIVORCED 11. BIRTHPLACE (County & Stote, or foreign country) 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT INDUSTRY GOVT. during most of working life, even if retired) EQUNTRY? Charleston, W. Va. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME remava Unknown Unknown 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address Edgewood, Md. (Yes, no, or unknown) (If yes give wor or dotes of service) Б Lynnwood A. Williams, 1911 Hanson Rodd 228-10-2076 burial, crematian, CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) signed by Page 4 may be retained by the haspital or attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse as the priar tak O FUNERAL DIRECTOR: After this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TARMINAL DISEASE CONDITION GIVEN IN PART 1(0) CERTIFICATION for use af Health NO YES 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER State Dept. 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) Not While 19 of work ot work should be 1963 to 21. I certify that (1) (this haspital) ottended the deceased from 1962, that (I) (we) last directar, page 3 should shauld be filed with the and that death occurred at 7:30 PM, from causes and on the date stated above. saw the deceased office on 220. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. Oct. 24, 1967 3 DIRECTOR PHYS 22d ADDRESS Louis Kahan. NAME (Type) Edgewood, Maryland 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Richmond VA. A.W. Bennett Funeral Remova Home 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Howard K. McComas & Son, Abingdon, Md.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 13979 deoth. and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY Pages 1 MARYLAND hours afte the b. CITY OR TOWN (If autside corparate limit c. LENGTH OF STAY IN 1b c. CITY OR TOWN Us autside carparate limits, write RURAL and give nearest town d. STREET ADDRESS IS RESIDENCE ON A FARM? HOSPITAL OR INSTITUTION (If not in haspital, give street address) filled in paper NO X YES The low requires that the death certificate be executed within NAME OF remove corban First Month Day Year physicion and completely DECEASED (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED Manths (ast birthday) Davs Hours WIDOWED DIVORCED and in ony 10a. USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR (County & State, or foreign country) 12. CITIZEN OF WHA ng mes of working life, even if retired) V- 10 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME the attending physical remains then pro-INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 6. SOCIAL SECURITY NO (Yes, no, peupknown) (If yes give wor ar dates of service) 0 INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line far, (a), (b), and (c). ONSET AND DEATH buriol-tronsit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) signed by DUE TO buriol, Conditions, if ony, which gave rise to immediate cause (o). DUE TO stoting the underlying couse **TO HOSPITAL OR ATTENDING PHYSICIAN:** The low re Page 4 may be retoined by the hospitol or ottending os the TO FUNERAL DIRECTOR: After this certificate hos been prior to last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? for use Health CERTIFICATION NO YES 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (County) (State) Nat While factory, street, affice bldg., etc.) at work ot work 10-25, 1967, that (1) (we) last 21. I certify that (1) (this hospital) attended the deceased fram, pluods 19 67, and that death accurred at 750 PM, fram causes and an the date stated above saw the deceased alive an_ 22a. SIGNATURE 22b. DATE SJGNED STAFF PHYS. M.D. DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, should 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (State 23b. DATE THEREOF (County) 23a. BURIAL, CREMATION 01041 REC'D BY REGISTRAR

MARYLAND STATE DEPARTMENT OF HEALTH

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